Veterans' Needs Feasibility Study – Recommendations Report

Missouri Veterans Commission

February 10, 2020

PUBLIC CONSULTING GROUP

TABLE OF CONTENTS

EXECUTIVE SUMMARY 3

PROJECT BACKGROUND 8

PROJECT TIMELINE 9

RESEARCH & OUTREACH METHODS 10

DEMOGRAPHIC ANALYSIS 12

VETERANS' HOMES / SKILLED NURSING FACILITIES 20

VETERANS' CEMETERIES 26

VETERAN SERVICES OFFICERS 34

ADULT DAY HEALTH CARE (ADHC) 36

APPENDIX A – VSO OUTREACH INTERVIEWS 48

APPENDIX B – RSMEANS COST ESTIMATE 49

APPENDIX C – MISSOURI MAP WITH COUNTY NAMES 50

EXECUTIVE SUMMARY

The Missouri Veterans Commission (MVC) engaged Public Consulting Group (PCG) to conduct a statewide study of the needs of veterans in Missouri. As part of this study, PCG reviewed current and projected veteran demographics and the geographic location of veterans, made recommendations to better meet the needs of veterans, and provided projected costs and potential risks for carrying out these recommendations. PCG used a number of research and data collection methods, including the review of state and US Department of Veterans Affairs (USDVA) documents, interviews and peer state research, and mapping software, to demonstrate any shifts in the veteran population across counties between 2018 and 2045.

RECOMMENDATION SUMMARY TABLE

Table 1: Recommendation Summary Table

Topic Area	Recommendation
Veterans' Homes / Skilled Nursing Facilities	The current and projected demand for skilled nursing beds for veterans **does not warrant the construction of an additional state veterans' home**.
Veterans' Cemeteries	Based on a conservative estimate of the population through 2045, MVC has an ample amount of developed cemetery capacity and **does not need to develop a new veterans' cemetery**.
Veterans Service Officers (VSOs)	VSOs provide an important service to veterans and help bring federal dollars into Missouri. **Hiring additional VSOs** can increase the level of assistance provided and the impact of these funds on the state's economy.
Adult Day Health Care (ADHC)	An ADHC facility for veterans in Missouri is the best way for the state to **take advantage of available federal funding to provide additional services to veterans** who may have medical needs but do not require 24-hour skilled nursing care.

DEMOGRAPHIC ANALYSIS

PCG used the USDVA's VetPop projections to determine the change in the veteran population over the coming decades. The analysis of the current and projected veteran population in Missouri from 2018 through 2045 reveals the following key findings:

- The total number of veterans is projected to decrease by just over 40%, but the geographic distributions across the state will remain similar to the present day.
- Although the population will decrease, the percentage of veterans 85+ and 17-44 will increase. This may result in the need for a different mix of service offerings to focus on these groups.
- The total number of women veterans will increase, as their percentage of the total population doubles by 2045.

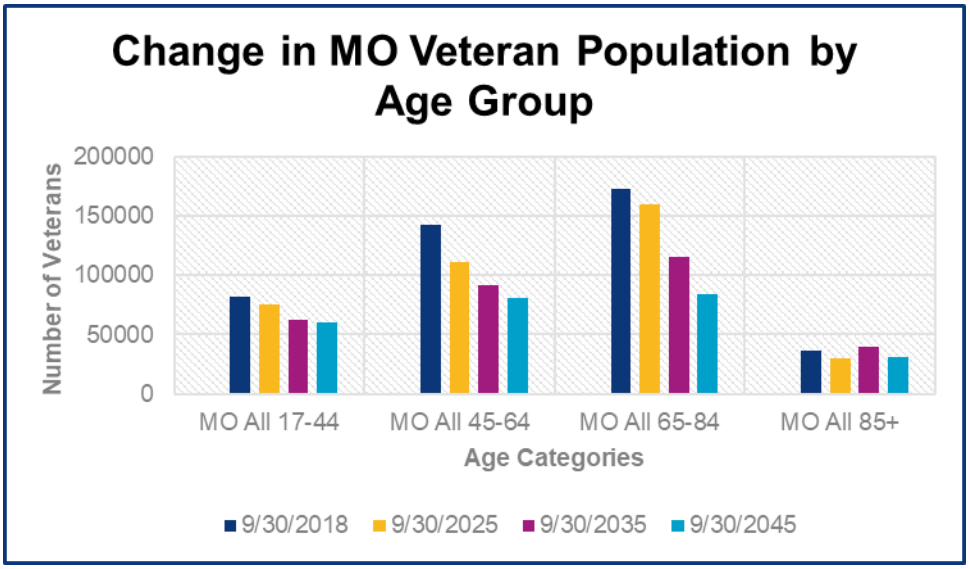


FIGURE 1: TOTAL CHANGE IN POPULATION BY AGE GROUP

SUMMARY OF RECOMMENDATIONS

PCG's recommendations focus on four key areas related to the needs of Missouri's veterans: Veterans' Homes and 24-hour Skilled Nursing Care; Veterans' Cemeteries; Veteran Services Officers (VSOs); and, Adult Day Health Care (ADHC). In each section, an overview of current services and research conducted is provided, along with other supporting information. The recommendations themselves are followed by an analysis of the risks that may accompany implementation and some suggested ways to mitigate those risks, along with an assessment of the costs and benefits of the recommendation. These recommendations and accompanying analysis are summarized here and detailed further in the body of this report.

Veterans' Homes / Skilled Nursing Facilities

The current and projected demand for skilled nursing beds for veterans does not warrant the construction of an additional state veterans' home at this time. The total number of veterans expected to require 24-hour skilled nursing care over the coming decades can be met by a combination of the beds currently made available by MVC, those provided by USDVA, which has 4,043 beds available in Missouri through its Contract Nursing Home Program, and the private market. Missouri has a total of over 56,000 skilled nursing beds statewide, and over a quarter of them, about 15,640 beds, were not occupied as of the most recent survey by the state's Certificate of Need (CON) program, in Q2 2019.[1] **If this same rate of occupancy is applied to the 4,043 beds available through the Contract Nursing Home Program, then 1,132 beds in this program are currently vacant**. Enhanced partnerships between MVC, the USDVA, and the private market, which are already in development, could ensure that skilled nursing beds are available for eligible veterans in need, without any additional construction.

The determination by MVC that many veterans on the waiting list did not actually need 24-hour skilled nursing care indicates that the MVC should consider providing additional services that may meet the needs of these veterans. Adult Day Health Care (ADHC), while not technically home-based, can accommodate a wider variety of needs than a skilled nursing facility, and provides a level of flexibility for veterans and their caregivers that a skilled nursing setting cannot match. It is also important to note that Missouri's number of state veteran home beds is capped at 1,257, per 38 CFR 59.40, leaving very little room to add beds to the current total of 1,238 without requesting an exception, which would significantly limit the locations where additional beds could be placed.[2] Additionally, the state cannot request construction grant funds for a facility that would put the state over the bed

[1] https://health.mo.gov/information/boards/certificateofneed/pdf/icfsnfsum.pdf
[2] https://www.ecfr.gov/cgi-bin/text-idx?SID=25a2b06073449dd66b703094c31bf56a&node=pt38.2.59&rgn=div5#se38.2.59_140

cap, meaning that Missouri would be forced to provide 100% of the construction funds for a new veterans' home, rather than the 35% it would need to provide in matching funds if it were below the cap.

Based on PCG's estimates and prior estimates gathered by MVC, construction costs for a new skilled nursing facility could exceed $60 million. As noted above, because this new facility would cause the state to exceed the bed cap, the state would bear the total construction cost.

Veterans' Cemeteries

PCG's analysis has determined that MVC does not need to develop a new veterans' cemetery at this time. Based on a conservative estimate of the population through 2045, MVC has an ample amount of developed cemetery capacity. In 2045, 46% of total developed veterans' cemetery capacity across the state will be available. Should there be a need for additional cemetery capacity, the MVC should first pursue building out undeveloped acres based on the area of the state with the most demand. In 2045, 73% of cemetery capacity, both developed and undeveloped, will be available across the state.

Data on the annual operational costs of each cemetery provided by MVC for Fiscal Year 2019 is displayed in Table 2: FY19 Operational Costs by Cemetery. Operational costs vary across the cemeteries due to differences in geographic location, number of acres, and number of interments, among other factors. By not building an additional cemetery, MVC will avoid spending $661,783 annually, which is the average operational cost across all cemeteries within the state. In addition to the financial benefits, MVC will also benefit by reducing the level of administrative effort that would be necessary to plan and build out an additional cemetery.

Table 2: FY19 Operational Costs by Cemetery

	Higginsville	Springfield	Bloomfield	Jacksonville	Ft. Leonard Wood
Annual Operational Cost	$654,125	$781,045	$793,824	$555,838	$524,081
Average Annual Operational Cost	**$661,783**				

Veteran Services Officers

Unlike many other states, Missouri does not allocate VSOs at the county level, but apportions them across the state. This has resulted in the state having a lower number of VSOs than other states with a similarly sized veteran population. According to MVC, the cumulative claims work done by their VSOs in all past years combined resulted in the award of $315 million in federal funds to over 20,000 Missouri veterans or their dependents in state fiscal year 2019. Given the impact of the work of the VSOs on veterans and the multiplier effect of the investment in these positions on the state's economy, MVC should invest in additional VSO as the budget allows.

Adult Day Health Care (ADHC)

The creation of an ADHC facility for veterans in Missouri is the best way for the state to take advantage of available funding to provide additional services to veterans who may have medical needs but do not require 24-hour skilled nursing care. The cost for startup is significantly lower, and while fewer veterans can be served at one time, there is strong potential for expansion to multiple locations across the state.

In order to contain costs, reduce start-up time, and increase potential to leverage existing resources, PCG focused on a current veterans' home as the best option for locating an ADHC facility. To determine the best site among existing homes, PCG ranked each of the current veterans' homes across several key categories, with a 1 indicating most appropriate for ADHC, and 7 least appropriate. Each category ranking was added together, with the lowest total score indicating the best choice to site an ADHC program. As Table 3 below shows, PCG recommends the St. Louis home as the best place to implement an ADHC program.

Table 3: ADHC Location Selection Matrix

Note: Figures below represent ranking in each category against other Missouri state veterans' homes.

Home	Occupancy %	ADHC Slots in current and adjacent counties	Need SN Applicants on W / L	Vets 65+ in County	Vets 65+ in Adjacent Counties	Unemployed Workers in County and Adjacent Counties	Beds Displaced? (Yes = 1, No = 0)	Staff in Place? (No = 1, Yes = 0)	Total Ranking Score	Overall Rank
Cameron	3.5	6	4	6	3	2	1	1	26.5	4
Warrensburg	5	5	1	3	4	3	1	1	23	2
Mount Vernon	3.5	4	3	5	2	4	1	1	23.5	3
Mexico	7	1	2	7	5	5	1	1	29	5.5
St. James	1	2	7	4	6	7	1	1	29	5.5
Cape Girardeau	6	3	6	2	7	6	1	1	32	7
St. Louis	2	7	5	1	1	1	0	0	17	1

Estimated Potential Operational Costs and Revenues

Assuming 40 total slots and a projected daily census of 30, Table 4 estimates revenues and expenses for varying combinations of veterans with 70% or higher service-connected disabilities and differing levels of financial contributions from non-service-connected veterans. Based on the anticipated costs to operate the ADHC program and transport veterans to and from the facility, a fairly significant daily copay will be required for the program to break even, unless a large number of 70% SCD veterans choose to participate. While the average cost for adult day care in Missouri is around $80 per day,[3] the range of private pay rates for the three other states that operate an ADHC program using USDVA grant and per diem funds runs from $65 through $184 per day. These peer states are a better comparison, as there is more standardization of required tasks for USDVA-funded ADHC than for private-market adult day care programs.

[3] https://www.seniorliving.org/adult-day-care/costs/

Table 4. Cost and Revenue Estimates					
Number of Veterans > 70% SCD	Daily Copay (for <70% SCD veterans)	Projected Per Diem Daily Revenue	Projected Annual Revenue (copay + per diem)	Total Cost for Care + Transportation	Cost After Revenues
0	$25	$2,622.60	$876,876.00	$1,872,000.00	$995,124.00
5	$25	$3,515.76	$1,076,596.95	$1,872,000.00	$795,403.05
10	$25	$4,408.92	$1,276,317.90	$1,872,000.00	$595,682.10
0	$50	$2,622.60	$1,071,876.00	$1,872,000.00	$800,124.00
5	$50	$3,515.76	$1,239,096.95	$1,872,000.00	$632,903.05
10	$50	$4,408.92	$1,406,317.90	$1,872,000.00	$465,682.10
0	$75	$2,622.60	$1,266,876.00	$1,872,000.00	$605,124.00
5	$75	$3,515.76	$1,401,596.95	$1,872,000.00	$470,403.05
10	$75	$4,408.92	$1,536,317.90	$1,872,000.00	$335,682.10
0	$100	$2,622.60	$1,461,876.00	$1,872,000.00	$410,124.00
5	$100	$3,515.76	$1,564,096.95	$1,872,000.00	$307,903.05
10	$100	$4,408.92	$1,666,317.90	$1,872,000.00	$205,682.10
0	$125	$2,622.60	$1,656,876.00	$1,872,000.00	$215,124.00
5	$125	$3,515.76	$1,726,596.95	$1,872,000.00	$145,403.05
10	$125	$4,408.92	$1,796,317.90	$1,872,000.00	$75,682.10
0	$150	$2,622.60	$1,851,876.00	$1,872,000.00	$20,124.00
5	$150	$3,515.76	$1,889,096.95	$1,872,000.00	$(17,096.95)
10	$150	$4,408.92	$1,926,317.90	$1,872,000.00	$(54,317.90)

It is important to note that the operational cost estimates included in Table 4 utilize cost of care estimates provided by ADHC programs at state veterans' homes in New York, Minnesota, and Hawaii. These three areas vary widely in terms of cost of living and health care costs. PCG reviewed cost comparison data across all four locations from the Genworth "Cost of Care Survey 2019," a widely recognized industry benchmark.[4] While reported Adult Day Health costs were relatively similar in St. Louis and each of these areas, the costs for nursing home care is much higher in the other three location, in some cases double the cost of care in St. Louis. This indicates that in general, costs for care may be lower in St. Louis than those included in the conservative estimate presented here.

The following additional assumptions inform these estimates:

1. The program will operate 5 days per week, 52 weeks per year.
2. MVC would be responsible for transportation costs, at a rate of $40 per day per participant.
3. The cost for care is $200 per day per veteran. This figure was derived from discussions with other states who are operating ADHC programs (additional details can be found on page 46).
4. Daily copays do NOT apply to 70% SCD or higher veterans.

[4] https://www.genworth.com/aging-and-you/finances/cost-of-care.html

PROJECT BACKGROUND

The Missouri Veterans Commission (MVC) provides services and support to veterans, service members, and their families. A veteran, as defined by the US Department of Veterans Affairs (USDVA), is a person who served in the active military, naval, or air service, and who was discharged under conditions other than dishonorable.[5] In Fiscal Year 2015, there were a total of 20.8 million veterans from each of these periods living in the United States: World War II (1941-1945), Korean Conflict (1950-1953), Vietnam Era (1955-1975), Peacetime (1975-1990) and the Gulf War Era (1990-2014). As a result of this expansive timeframe in which a veteran might have served, many states including Missouri have a mixture of generations of veterans. These generational differences amongst veterans mean that older veterans may have drastically different needs compared to younger veterans returning from recent deployments.

MVC issued a Request for Proposal (RFP) to select a vendor to conduct a statewide study to determine the needs of veterans in the state. PCG was chosen to review current and projected veteran demographics and the geographic location of veterans within Missouri. The project team used this and other information to make recommendations to better meet the needs of the veterans, and to provide projected costs and potential risks of carrying out these recommendations.

The focus of this project is to provide MVC with a clear understanding of the needs of veterans across the 3 pillars of services that they provide – Veterans Homes, Veteran Services Officers, and Veterans Cemeteries - and will have several options to address these needs now and over the next 30 years. More specifically, the goals of Veterans' Needs Feasibility Study are:

Goal 1	**Understand the health care needs of Missouri veterans, now and in the future.** MVC seeks an assessment of the health care needs of veterans in the state, both now and in the future, as demographic shifts in the population of veterans impacts the services required.
Goal 2	**Assess the ability of current facilities and services to meet these needs.** MVC seeks to determine whether the current array of care facilities and services, including state Veterans Homes**,** state Veterans Cemeteries, and services offered by Veteran Services Officers (VSOs) have the capacity and services needed to meet the needs of veterans.
Goal 3	**Determine what additional services are necessary to meet veterans' needs.** MVC seeks to understand whether there are services that could better help the state meet its mission "to serve Veterans as the first choice in Skilled Nursing Care; enduring choice in Benefits Assistance; and proven choice in a Dignified Resting Place."
Goal 4	**Understand the advantages, challenges, risks, costs of adding additional services and / or care facilities.** MVC seeks estimates of potential costs for construction and operation of new facilities and / or services, as well as an analysis of risks that may be associated with each recommended activity.

[5] http://www.gpo.gov/fdsys/pkg/USCODE-2011-title38/pdf/USCODE-2011-title38-partI-chap1-sec101.pdf

PROJECT TIMELINE

This project took place over 10 months, beginning in March 2019. The below timeline identifies the phases and work products associated with this engagement.

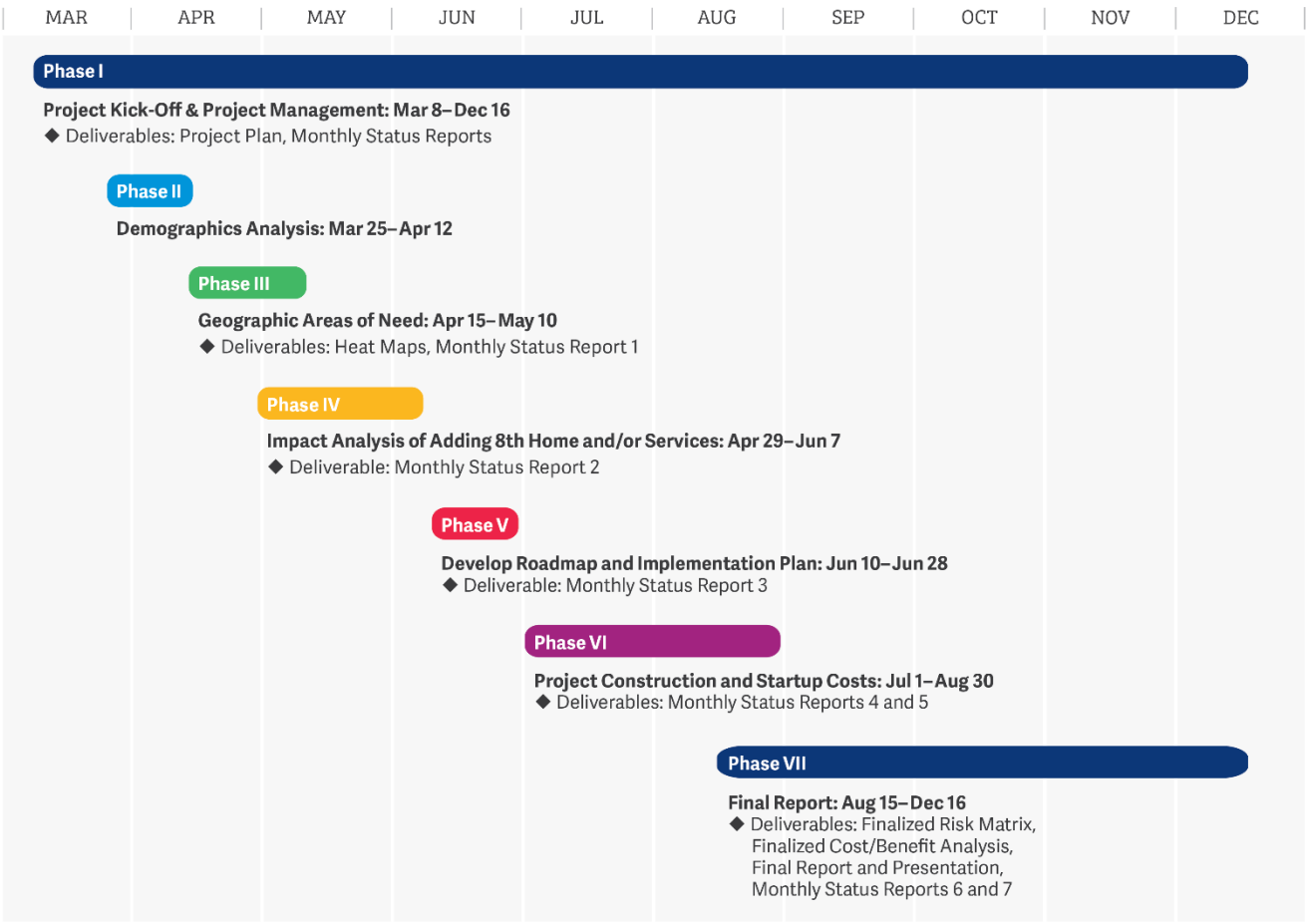


FIGURE 2: VETERANS' NEEDS FEASIBILITY STUDY PROJECT TIMELINE

RESEARCH & OUTREACH METHODS

This section details the tools, sources, and techniques that PCG used to gather information for this report. Figure 3 gives an overview of the approach used to perform analyses and develop recommendations for meeting the needs of MVC related to this engagement, and additional details are included in the section that follows. Sources included:

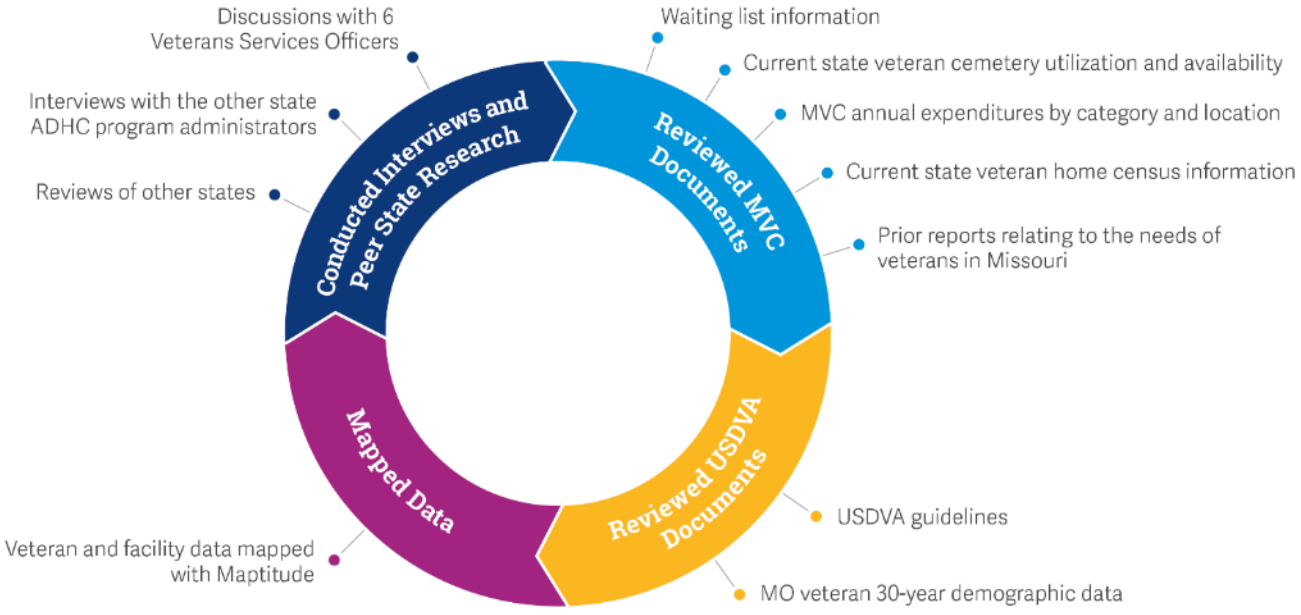


FIGURE 3: APPROACH TO PERFORM ANALYSES AND DEVELOP RECOMMENDATIONS

DOCUMENT REVIEW

PCG reviewed several different kinds of documents in the development of this recommendations report. Most materials were either shared by the MVC or produced by the US Department of Veterans Affairs (USDVA). Documents shared by the MVC include the following:

- Waiting list information (shared with de-identified data)
- Current state veteran cemetery utilization and availability
- MVC annual expenditures by category and location
- Current state veteran home census information
- Prior reports relating to the needs of veterans in Missouri

USDVA documents were generally utilized as a reference to determine guidelines and program requirements. One important USDVA source of information used for projections is the "VetPop" database, provided by the National Center for Veterans Analysis and Statistics (NCVAS), a division of the USDVA.

The Veteran Population Projection Model 2016 (VetPop2016) provides the latest official veteran population projection from the VA. VetPop2016 is provided by the VA and used for strategic, policy planning, and budgeting within VA and by external organizations such as other federal agencies, Congress, state governments and other organizations.

The VetPop2016 model, developed by the VA's Office of the Actuary, uses the best available veteran data at the end of FY 2015 as the base population to create a population projection from FY 2015 to FY 2045. The baseline FY 2015 numbers are determined by the by the office of Predictive Analytics and Actuary based on military service information from the VA, the Department of Defense (DoD), and demographic information from national surveys and commercial databases. The VA provides multiple breakdowns of data in VetPop2016, including age, gender,

time in service, and period of service. The data provides a projection of future veterans' populations on a county level basis nationwide.

Other information utilized in the development of this report include labor and workforce information from the Missouri Economic Research and Information Center (ERIC), and census by zip code information from the American Community Survey (ACS) produced by the US Census Bureau.

MAPPING

As part of this project, PCG created a number of maps that display the current and projected veteran populations, as well as the radius, in both time and miles, surrounding each of the current state and federal veterans' cemeteries in Missouri. PCG utilized a Geographic Information System (GIS) software package to produce the maps included in this report. Maptitude GIS allows users to combine demographic data with geographic locations to conduct and present unique visual analysis. Maptitude's software includes internal statistical calculations which separate the data entered by PCG into distinct categories which are displayed in graduated shading.

Mileage "drive bands" are used in this report to create estimates of access to cemeteries through accessible roads as opposed to a general radius, or "as the crow flies" measurement. Drive bands are calculated by marking each cemetery location as a point. From here, any accessible roads are identified, and miles are counted following these routes. The summation of the different routes creates the complete drive band around the selected point. In consultation with MVC, PCG performed analysis using both a 75-mile radius and 1.5-hour drive bands to determine access to current cemetery facilities.

INTERVIEWS AND PEER-STATE RESEARCH

As part of PCG's project management plan, regular status meetings were conducted with MVC's project team, allowing for opportunities to gather information from state staff. In addition to these meetings, PCG conducted interviews with both internal and external stakeholders, focused on the following:

- Veteran Services Officers (VSOs) – PCG conducted phone interviews with 4 VSOs and 2 VSO supervisors to learn more about their work, the resources available to them, and the needs of the veterans that they serve. Each of the VSOs spoke openly and candidly about their work, the challenges that they face, and some potential opportunities. This information provided important context and background on the current relationship between veterans, the county, and the USDVA. A full summary of the information gathered from the VSOs can be found in Appendix A – VSO Outreach Interviews.

- Adult Day Health Care (ADHC) program administrators – PCG conducted interviews with administrators in the three states that currently operate an ADHC facility as part of their state veterans' home program. Program leadership from New York, Minnesota, and Hawaii provided a significant amount of information about their current programs, how they got started, and the major issues that they faced and continued to face to develop and run a program that meets the needs of veterans and their families. Much of the information that was shared is included in the ADHC section of this report.

DEMOGRAPHIC ANALYSIS

OVERVIEW

Missouri's veteran population, estimated at 434,373 in September 2018, is the 15th largest in the nation. The percentage of women veterans falls just slightly below the national average of 9.7%, and more than three quarters of veterans in the state served during wartime. The total population is projected to drop significantly over the next 30 years, to just over 257,000 by 2045, a reduction of over 40% in the total number of veterans in the state. The drop in the number of veterans combined with the continued increase of the total population in the state means that the percentage of the total population who are veterans will drop from 7% in 2018 to 5% in 2030, the latest year when projections for the general population are available.[6] These changes, and the shifts in the demographics of the remaining population, will impact the way that services are provided for veterans. It is important that MVC adjust its service array to accommodate these changes to meet its mission of being the first choice for veterans seeking assistance with skilled care needs. This section details the demographics and geographic location of the current veteran and projected population of veterans in the state over the next several decades.

CURRENT VETERAN POPULATION

To determine the current veteran population in Missouri, PCG used US Department of Veterans Affairs (USDVA) VetPop projections effective September 30, 2018. In consultation with MVC, September 30, 2018 data was chosen as the baseline data because it was the closest to the date to the start of this project. This data shows a slight majority of the current veteran population in Missouri is under the age of 65, but this still means that 48% are of the age at which long-term care utilization is most likely. Table 5, Table 6 and Table 7 provide a breakout of current population by age, gender, and period of service. The "heat maps" in Figure 4 and Figure 5 show the relative density of the veteran population across the state, and their proximity to current MVC facilities.

Table 5: Veterans by Age - 2018

	17 - 44	45 - 64	65 - 84	85+	Total
Total Number	81,759	142,601	173,383	36,630	434,373
% of Population	**19%**	**33%**	**40%**	**8%**	**100%**

Table 6: Veterans by Gender - 2018

	Women	Male	Total
Total Number	36,304	398,069	434,373
% of Population	**8%**	**92%**	**100%**

Table 7: Veterans by Period of Service – 2018

	Wartime	Peacetime	Total
Total Number	333,908	100,465	434,373
% of Population	**77%**	**23%**	**100%**

[6] https://archive.oa.mo.gov/bp/projections/TotalPop.pdf

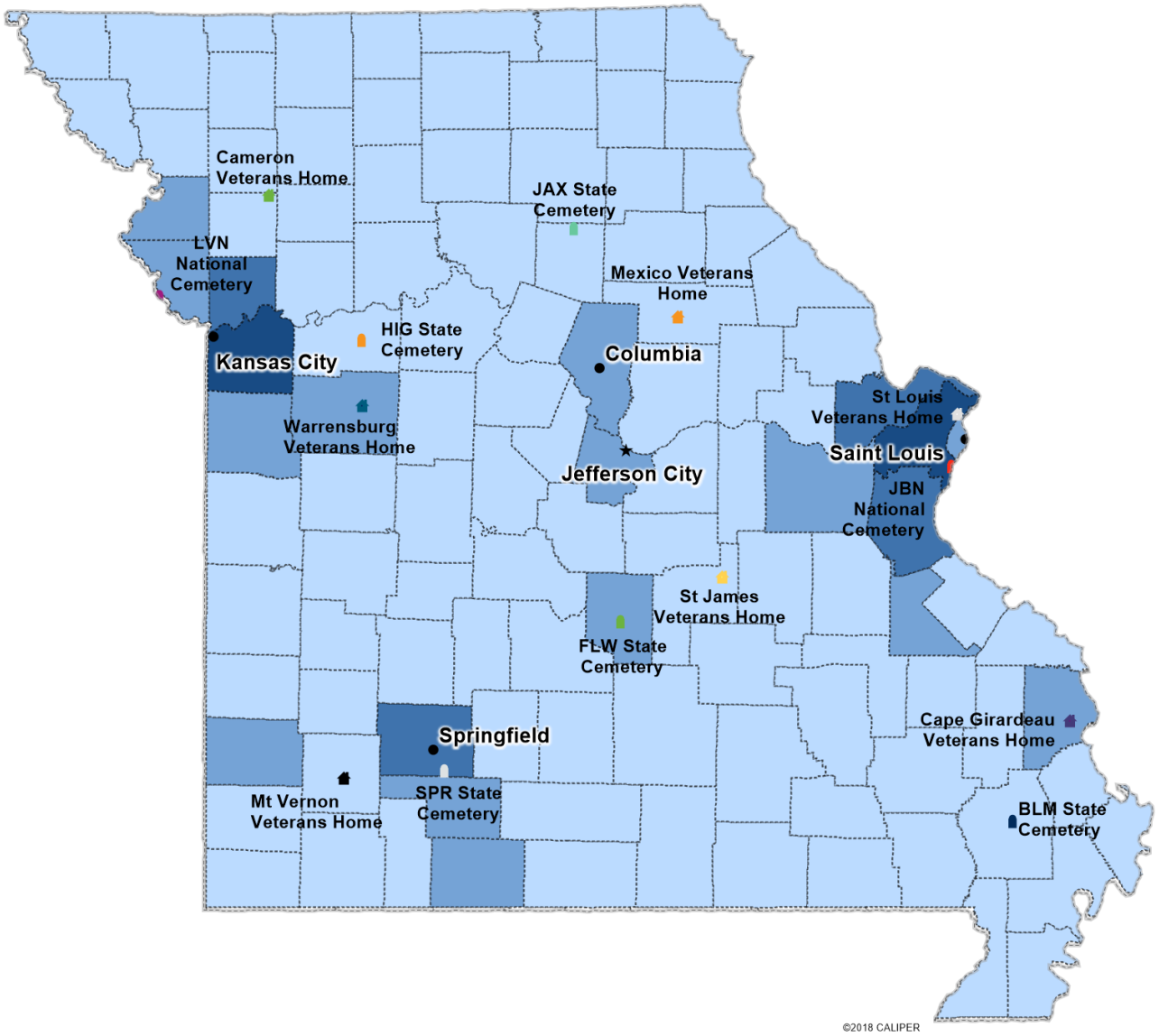


FIGURE 4: VETERAN POPULATION BY COUNTY - 2018

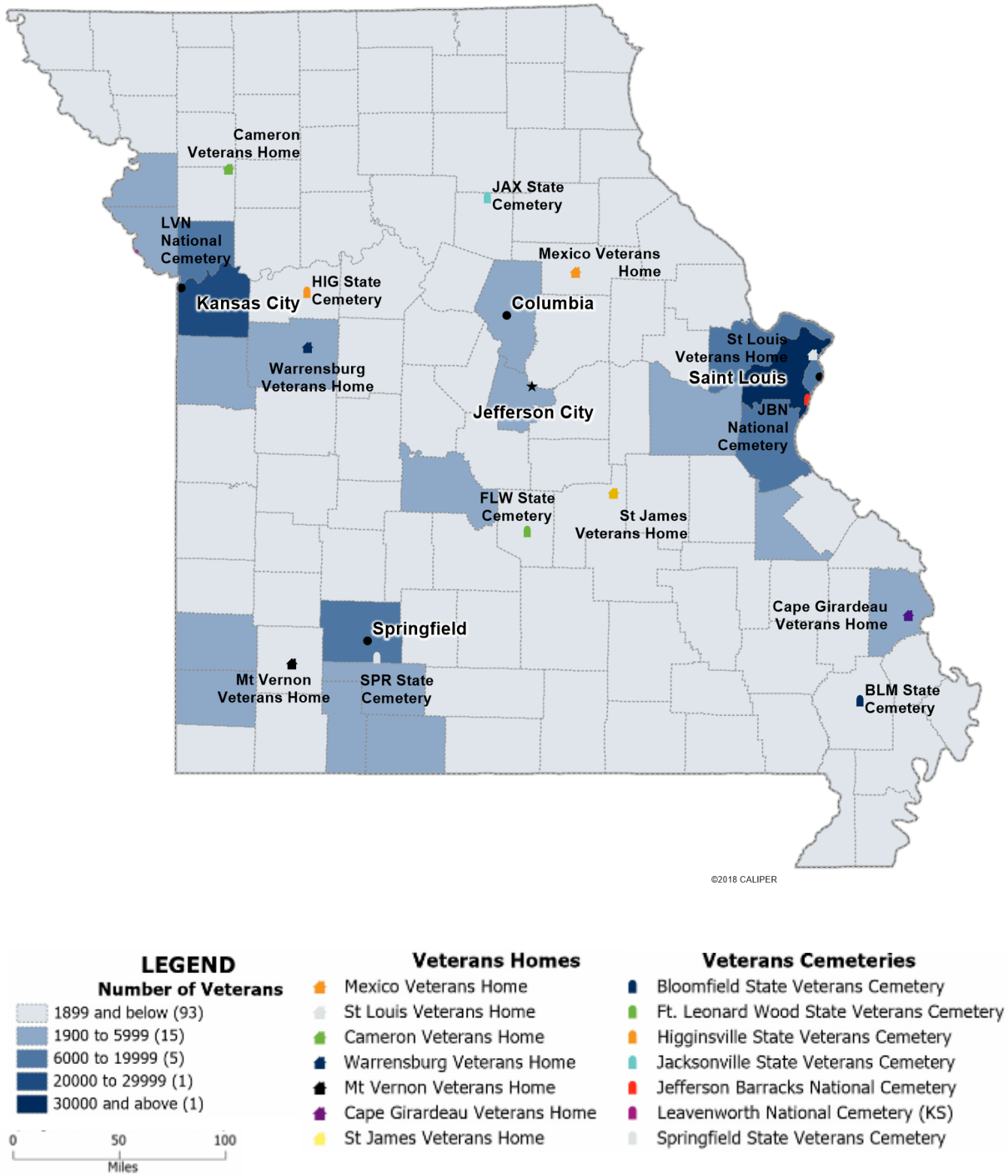


FIGURE 5: VETERAN POPULATION AGES 65+ BY COUNTY - 2018

PROJECTED VETERAN POPULATION

PCG used the USDVA's VetPop projections to determine the change in the veteran population over the coming decades. Table 8 indicates the decline in total population between 2018 and 2045. Table 9 and Table 10 show the projected shift in demographics across age and gender. While the total number of veterans will drop significantly, the ages and genders of the population will be different from the current day. According to these projections, the percentage of veterans in the oldest and youngest segments of the population will both increase, with those in the middle either remaining the same, or losing ground. Of particular note, the percentage of women veterans is projected to double, with the total number actually increasing slightly by 2045 from the 2018 population. The figures below further illustrate these shifts. One thing that will not change significantly is the geographic distribution of veterans across the state. Compared with the 2018 heat maps in Figure 4 and Figure 5, the 2045 heat maps in Figure 6 and Figure 7 show little change other than an overall reduction in total numbers across the board.

Table 8: Total Projected Veteran Population 2018-2045

	Estimated Population, 2018	Projected 2025 Population	Projected 2035 Population	Projected 2045 Population
Total Number	434,373	378,021	309,299	257,088

Table 9: Veterans by Age - 2045

	17 - 44	45 - 64	65 - 84	85+	Total
Total Number	59,973	81,421	84,314	31,380	257,088
% of Population	**23%**	**33%**	**33%**	**12%**	**100%**

Table 10: Veterans by Gender - 2045

	Women	Male	Total
Total Number	41,743	215,345	257,088
% of Population	**16%**	**84%**	**100%**

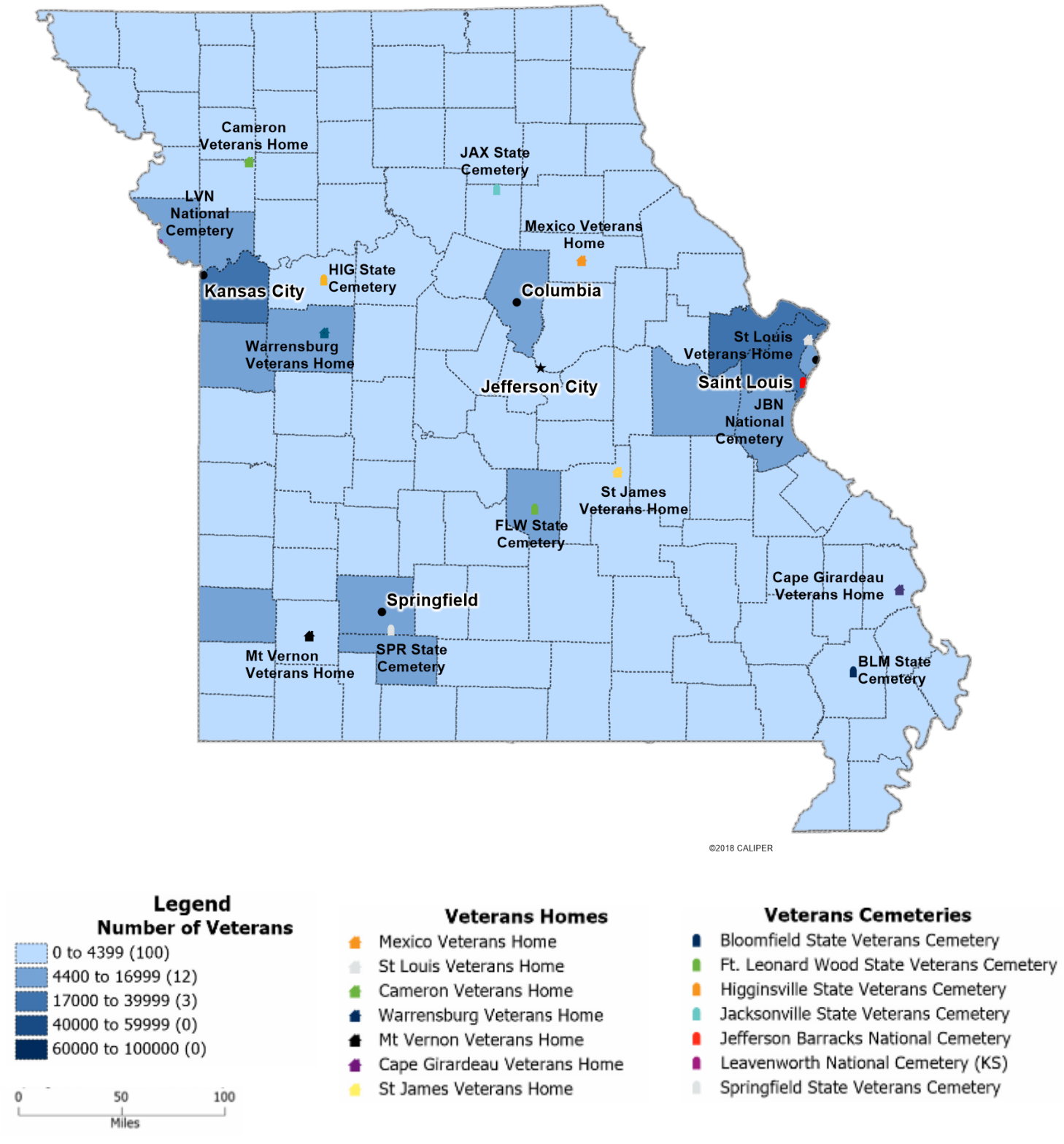


FIGURE 6: PROJECTED VETERAN POPULATION BY COUNTY - 2045

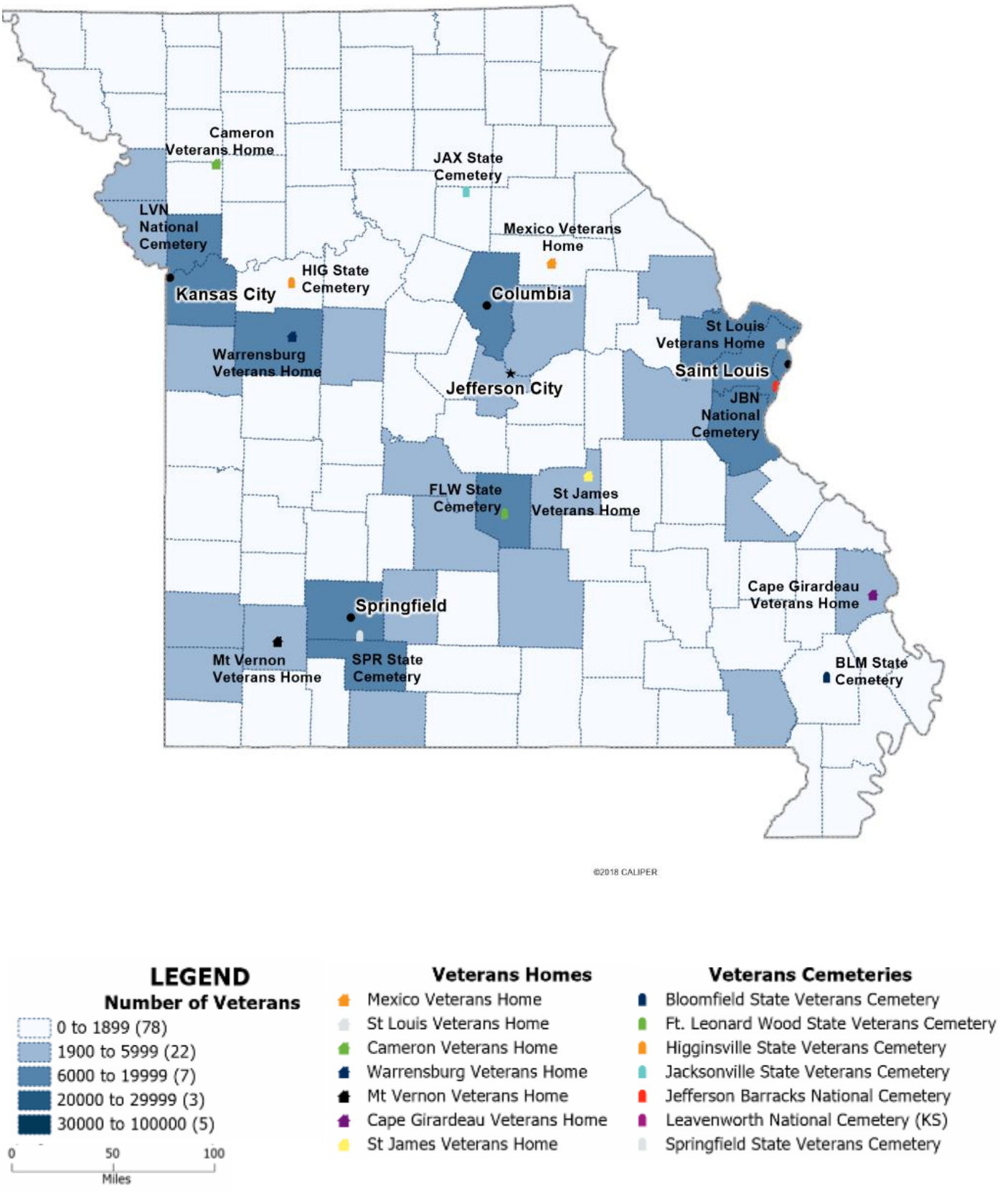


FIGURE 7: PROJECTED VETERAN POPULATION 65+ BY COUNTY - 2045

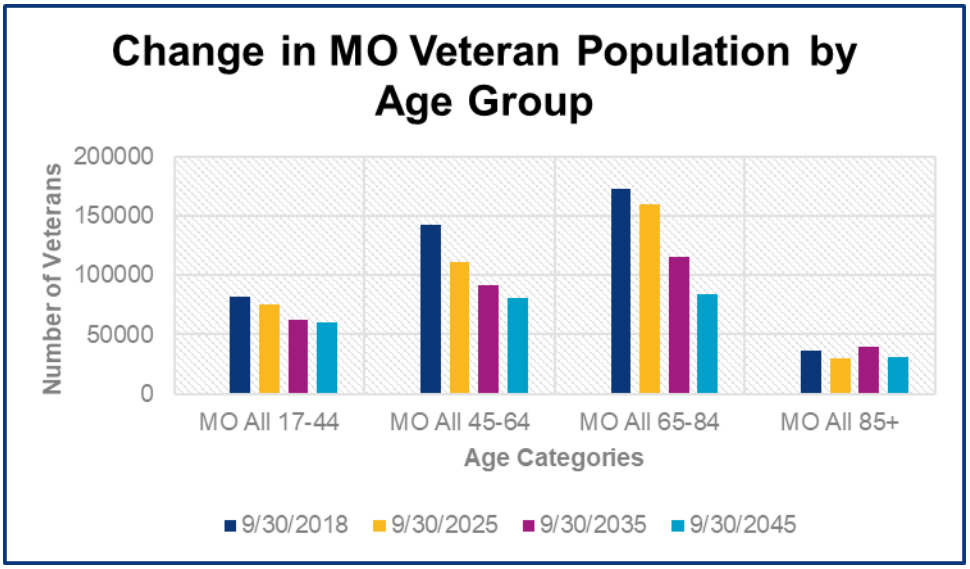


FIGURE 8: TOTAL CHANGE IN POPULATION BY AGE GROUP

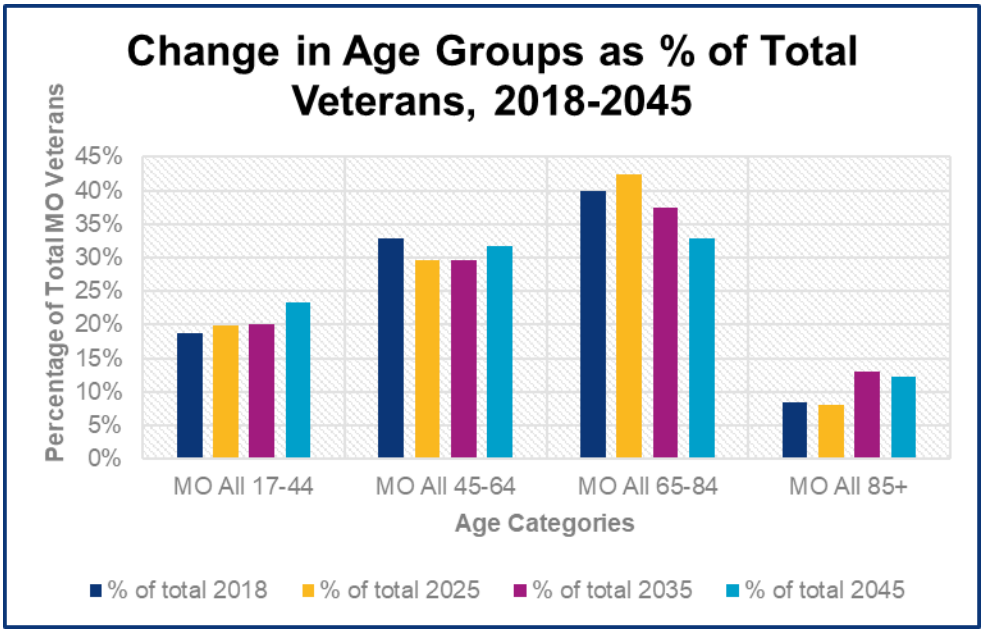


FIGURE 9: CHANGE IN AGE COMPOSITION OF MISSOURI VETERANS POPULATION

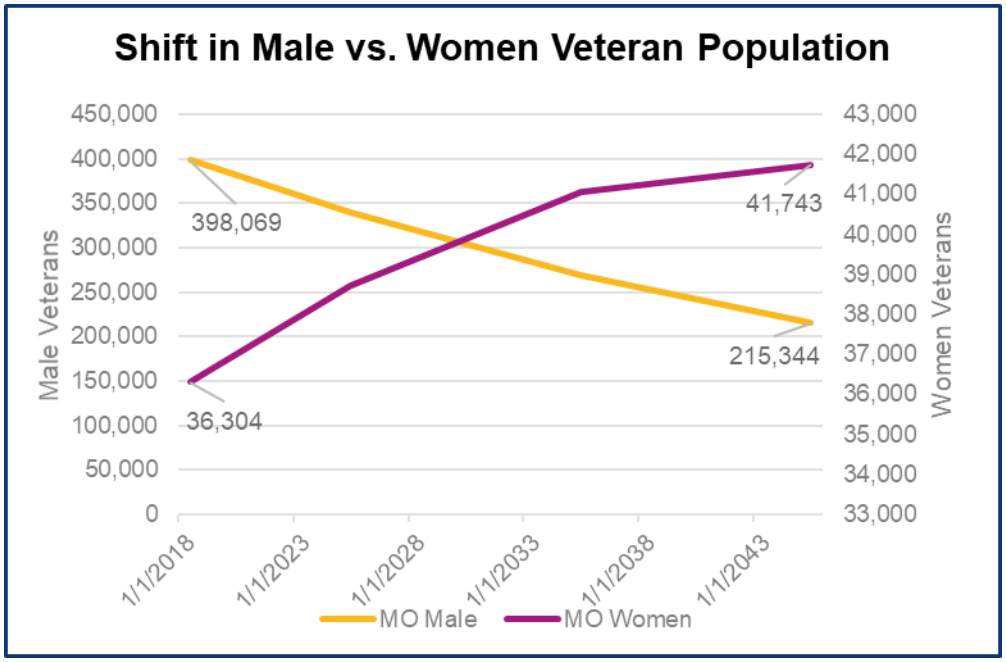


FIGURE 10: CHANGE IN MALE AND WOMEN VETERAN POPULATION 2018-2045

FINDINGS

The analysis of the current and projected veteran population in Missouri from 2018 through 2045 reveals the following key findings:

- The total number of veterans is projected to decrease by just over 40%, but the geographic distributions across the state will remain similar to the current day.
- Although the population will decrease, the percentage of veterans 85+ and 17-44 will increase. This may result in the need for a different mix of service offerings to focus on these groups.
- The total number of women veterans will increase, as their percentage of the total population doubles by 2045.

VETERANS' HOMES / SKILLED NURSING FACILITIES

OVERVIEW

MVC currently operates seven veterans' homes across the state, with a current capacity of 1,238 beds providing 24-hour skilled nursing care to eligible veterans. The current facilities are designed to serve veterans who are found to need institutional health care services, as determined by a team of professionals across the fields of medicine, social work, and facility administration. At present, several of the homes are operating at less than full capacity, despite the existence of a waiting list of veterans who have been determined to need 24-hour skilled nursing care. This is in part due to the difficulty in finding adequate numbers of appropriately qualified employees to staff these homes. While MVC has made significant strides in addressing staffing concerns in recent months, this is still a concern that merits consideration when determining whether additional facilities should be recommended. Table 11 details the capacity and occupancy of each of the veterans' homes as of October 27, 2019.

Table 11: Current State Veterans' Homes

Home	Census (Oct 2019)	Capacity	Occupancy Rate
Cameron	185	200	92%
Cape Girardeau	143	150	95%
Mexico	148	150	99%
Mount Vernon	185	200	92%
St. James	136	150	90%
St. Louis	171	188	91%
Warrensburg	188	200	94%
Total	**1156**	**1238**	**93%**

TRENDS IN LONG TERM CARE

PCG reviewed several sources to identify current trends in the long-term skilled care sector. The research identified numerous factors such as aging of the baby-boomer generation, new technologies, concerns about quality, and payment issues that are influencing the future of long-term care and shaping the settings and residential models for long-term care. These key forces and implications are summarized in Table 12.

Table 12: Key Forces Shaping the Future of Long-Term Care for Older Adults in the United States[7]

Current Trends	Possible Implications
Aging of "baby boomers"	*Experimentation and diversity in forms of care will increase.*
Emphasis on personal choice and person-centered care	*Choice in all aspects of care will increase.*
Emphasis on quality improvement	*Publicly available quality ratings will increasingly drive quality improvement.*
Technological innovation	*Robots, smart homes, electronic health monitoring and communication, and other innovations will reduce dependency on human caregivers.*
Search for new treatments for dementia	*Development of new treatments for dementia will be a major determinant of the need for and format of long-term care.*
Funding of care by private payment and Medicaid	*Dependency on private payment and Medicaid is likely to continue; hopes for long-term care insurance have not been realized.*
Financial pressure to contain public costs	*There will be increased accountability among both home-based and long-term care services, as well as increased copayments and deductibles.*
Trend toward home care rather than institutional care	*The trend toward home-based service models will continue and increase for persons who do not have extensive care needs or dementia.*
Workforce needs and shortages	*The availability of sufficient staff to serve as nursing assistants and home health care aides will impact cost and availability of long-term care services.*

As the baby boomer generation and the veteran population continue to age, there is increasing demand for long-term care services with an emphasis on home-based care. This is a result of their "preference towards personal choice and person-centered care, diversity of care options" and remaining at home, which is becoming a central theme in the models of providing long-term care.[8]

This trend towards home and community-based settings (HCBS) has been increasing over the past two decades. With various administrative efforts, financial incentives and broader statutory authority from Congress for states to provide more HCBS services, Medicaid and the VA have shifted towards expanding HCBS to honor the preferences of individuals and to allow more patient-centered and consumer-driven models of care.[9] According to the AARP, most individuals express a strong preference for remaining in their homes and communities rather than in institutions.[10] Furthermore, HCBS is "less costly than facility-based options and growth in long term services and support (LTSS) expenditures can be moderated by moving toward the provision of more HCBS" according to the VA. However, because of current contracting requirements and USDVA grants that provide states with funding

[7] Adapted from Sloane, Philip, et al. "What Will Long-Term Care Be Like in 2040?" *North Carolina Medical Journal*, www.ncmedicaljournal.com/content/75/5/326.full.pdf.
[8] Sloane, Philip, et al. "What Will Long-Term Care Be Like in 2040?" *North Carolina Medical Journal*, www.ncmedicaljournal.com/content/75/5/326.full.pdf.
[9] Congressional Research Service, "Long-Term Care Services for Veterans," February 2017, https://fas.org/sgp/crs/misc/R44697.pdf
[10] AARP, "Home and Community Preferences of the 45+ Population," November 2010, http://assets.aarp.org/rgcenter/general/home-community-services-10.pdf.

for facility construction or acquisition of nursing homes and adult day health care (ADHC) facilities, states may generally favor maintaining institutional care rather than exploring non-institutional alternatives.[11] One of the models that is also considered HCBS is ADHC, which includes elements of both institutional and non-institutional care. ADHC is part of a communal care setting where participants can receive health services, personal care and social interaction before returning home. With the USDVA funding that is available, ADHC may serve as a better form of investment as it establishes that long-term care needs are met both humanely and cost-effectively and adapts individuals' preferences to care in a home setting. ADHC is an option that ultimately lies in the middle path to the shift towards care in a home-like setting.

CURRENT DEMAND

PCG calculated the current demand for skilled nursing facilities by determining the total number of veterans in the state who could be assumed to need 24-hour skilled nursing care, based on the demographics of the current population of nursing home residents in the US and in Missouri.

24-hour Skilled Nursing Care Need Estimate

In order to project the size of the veteran population who will need skilled nursing services now and in the future, PCG referenced the nursing home population for those 18 and older according to the Centers for Disease Control and Prevention (CDC).[13] The CDC breaks this population out by gender, allowing the estimate to account for the higher level of 24-hour skilled nursing care utilization by females, and the impact of that difference on the Missouri veteran population, which is overwhelmingly male. PCG applied the national percentages of male and female utilization to the total number of occupied skilled nursing beds in Missouri to create an estimate of the total male and female population in skilled nursing beds in the state. This was used to calculate the percentage of all males and females over the age of 18 in Missouri utilizing 24-hour skilled nursing care, which was then applied to the population of Missouri veterans in 2018, and the projected population in 2025, 2035, and 2045. Table 13 breaks out the percentage of current occupied Missouri skilled nursing beds by gender; Table 14 details the calculations described in this section.

Table 13: All Missouri Occupied Skilled Nursing Beds by Gender

Gender	Percentage of Current Skilled Nursing Population[12]	# of Missouri Skilled Nursing Beds
Male	35.4%	14,116
Female	64.6%	25,761
All	100%	39,877

[11] Congressional Research Service, "Long-Term Care Services for Veterans," February 2017.
[12] https://www.cdc.gov/nchs/data/series/sr_03/sr03_43-508.pdf, pg. 76.
[13] https://www.cdc.gov/nchs/data/series/sr_03/sr03_43-508.pdf, pg. 76. Please note that this report uses the term "nursing homes" to include skilled nursing facilities, and differentiates only between other residential settings, such as assisted living settings. Please see page 3 of the report linked here for more information.

Table 14: 24-hour Skilled Nursing Care Need Estimate Calculations			
Missouri Population Type	**Population[14]**	**# of Occupied Skilled Nursing Beds in Missouri**	**% of population in skilled nursing beds in Missouri**
Males 18+	2,303,089	14,116	0.6129%
Females 18+	2,446,533	25,761	1.0529%

Applying the percentages derived in Table 14 to the population of male and female veterans in Missouri in 2018 and the projected population over the coming decades provides a sense of the potential veteran demand for skilled nursing beds and how it will change over time.

Table 15: 24-hour Skilled Nursing Care Need Estimate					
Year	**Missouri Veteran Population**	**Total Number of Veterans Expected to Utilize 24-Hour Skilled Nursing Care Statewide**	**Total Number of MVC Skilled Nursing Beds**	**Community Skilled Nursing Home Beds for Veterans[15]**	**Private Market Skilled Nursing Beds**
2018	434,373	2,822	1,238	• 1132 additional unoccupied beds at 35 Contracted Nursing Homes • 132 beds at 3 USDVA CLCs	• 14,508 additional unoccupied beds in private market homes in Missouri
2025	378,021	2,487	1,238		
2035	309,299	2,076	1,238		
2045	257,088	1,759	1,238		

Based on the availability of 1,238 MVC beds, 1,132 VA Contracted beds, 132 VA CLC beds, and 14,508 unoccupied beds in the private market, Veterans in Missouri have many available resources for skilled nursing care. As Table 15 indicates, the need for 24-hour skilled nursing care among the veteran population in Missouri will decline along with the total veteran population, and there are significant resources available outside of MVC to assist those that are expected to need skilled care. An important factor to keep in mind is that it there is no accurate way to estimate the number of veterans who may be utilizing non-MVC skilled nursing facilities at this time, and that while the MVC should carry out its mission of being the first choice for veterans seeking 24-hour skilled nursing care, it need not see itself as the sole provider of 24-hour skilled nursing care to veterans.

24-Hour Skilled Nursing Care Waiting List

MVC maintains a waiting list for veterans who wish to be considered for a spot in a state veterans' home when one becomes available. Only those who are determined to need 24-hour skilled nursing care are eligible for state veteran home beds.

It is important to note that the MVC has made significant efforts during the course of this project to address the needs of veterans on the current waiting list. MVC is revising its waiting list application to facilitate easier management of applications. MVC continues to connect veterans and families with resources that might better suit their needs, including those available through the USDVA. This outreach has supported the contention that a

[14] https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=CF, effective July 1, 2018.
[15] Bed number calculated by applying statewide skilled nursing vacancy rate of 28% to total number of beds currently contracted through USDVA's Contract Nursing Home program, which was 4043 at the time of this calculation. USDVA may access these beds based on availability and need; the total number in use varies over time.

large number of those on the waiting list are seeking to access the resources that they know to be available, regardless of whether they are appropriate to meet their own needs.

As of October 2019, the total number of veterans on the waiting list that have been determined to need 24-hour skilled nursing care was 412. **As of January 2020, there are approximately 300 veterans on the list, of which approximately 100 statewide are ready to admit; MVC is conducting face to face assessments to validate this information**. In the months following the start of this project in March 2019, MVC undertook a large-scale effort to reach out to those on the waiting list, particularly those not indicated as needing 24-hour skilled nursing, to connect them with other resources that may better meet their needs. Some of those on the waiting list have been assisted through partnerships with USDVA to identify appropriate available beds. The veterans currently on the waiting list are accounted for in the "Total Number of Veterans Expected to Utilize 24-Hour Skilled Nursing Care Statewide" column in Table 15.

RECOMMENDATION

The current and projected demand for skilled nursing beds for veterans does not warrant the construction of an additional state veterans' home at this time. The total number of veterans expected to require 24-hour skilled nursing care over the coming decades can be met by a combination of the beds currently made available by MVC, those provided by USDVA, and the private market. Each USDVA medical center, through the Contract Nursing Home program, contracts with community based skilled nursing facilities for access to beds based on need and availability. Because this number can fluctuate based on a variety of factors, it is difficult to assign a specific number of available beds at a given time. However, the USDVA's website currently lists 35 Contracted Nursing Homes with a total capacity of 4043 beds, in addition to 3 USDVA-operated Community Living Centers (CLCs) with an additional 132 beds.[16] Missouri has a total of over 56,000 skilled nursing beds statewide, and over a quarter of them, about 15,640 beds, were not occupied as of the most recent survey by the state's Certificate of Need (CON) program, in Q2 2019.[17] **If this same rate of occupancy is applied to the 4043 beds available through the Contract Nursing Home Program, then 1132 beds in this program are currently vacant**. Enhanced partnerships between MVC, the USDVA, and the private market, which are already in development, could ensure that skilled nursing beds are available for eligible veterans in need, without any additional construction.

MVC should consider providing additional services that may meet the varying needs of veterans. Adult Day Health Care (ADHC), while not technically home-based, can accommodate a wider variety of needs than a skilled nursing facility, and provides a level of flexibility for veterans and their caregivers that a skilled nursing setting cannot match. It is also important to note that Missouri's number of state veteran home beds is capped at 1,257, per 38 CFR 59.40, leaving very little room to add beds to the current total of 1,238 without requesting an exception, which, even if granted, would significantly limit the locations where additional beds could be placed.[18] Additionally, the state cannot request construction grant funds for a facility that would put the state over the bed cap, meaning that the state would be forced to provide 100% of the construction funds for a new veterans' home, rather than the 35% it would need to provide in matching funds if it were below the cap.

RISKS & MITIGATION

A risk with all projections is that actions that were unanticipated at the time of the projection will alter the assumptions on which it is based. In the case of projections of veterans, there is the potential for a new or expanded military conflict that leads to a larger number of veterans. This could also change the age, gender, and geographic distribution of veterans across the state, depending on the duration and severity of the conflict. There is no real opportunity to mitigate this risk at present, other than to review, on an annual or biannual basis, the demographics of the current veteran population and compare to the projected figures.

Some other potential risks are those that could impact the availability of 24-hour skilled nursing care beds across the state. Cuts to funding at the USDVA, which also provides 24-hour skilled nursing care beds, or changes to the

[16] https://www.accesstocare.va.gov/CNH/FindCommunityNursingHomes?LocationText=MO&SortOrder=1&Radius=50&UserLatitude=-1&UserLongitude=-1, accessed October 23, 2019.
[17] https://health.mo.gov/information/boards/certificateofneed/pdf/icfsnfsum.pdf
[18] https://www.ecfr.gov/cgi-bin/text-idx?SID=25a2b06073449dd66b703094c31bf56a&node=pt38.2.59&rgn=div5#se38.2.59_140

way health care and 24-hour skilled nursing care is funded or paid for, could impact the availability of 24-hour skilled nursing care beds in the private sector. Changes in demand, which are anticipated as the generations approaching the 65+ age range begin to seek options other than residential care, should help to mitigate any of those scenarios.

COSTS & BENEFITS

The state will benefit by not taking on the additional costs to build and maintain an additional veterans home, and can utilize those funds to establish other services, such as ADHC, that adhere more closely to the trends in long-term care described earlier in this section. Other states requesting 65% federal matching funds in recent years for homes in the range of 120 beds are seeking between $22 and $25 million in matching funds,[19] meaning that the total cost would be between $34 and $38 million. These comparisons are likely conservative; prior estimates obtained by MVC for the construction of a new veterans' home were closer to $60 million in total. As noted above, adding additional 24-hour skilled nursing beds would cause the state to exceed its bed cap, and the state would not be eligible for federal matching funds. This means that the state would bear the total construction cost of $60 million or more. In addition, the state would have annual operating costs of approximately $15 million. The state would need to dedicate facilities staff, procurement staff, and program staff to oversee the bidding process, construction, staffing, and outreach to enroll new residents.

.

[19] https://www.nasvh.org/documents/links/FY16-VA-Priority-List-signed.pdf

VETERANS' CEMETERIES

OVERVIEW

The veterans' cemetery program creates a network of facilities that honor the state's veterans for their service and sacrifice. As part of this program, MVC ensures that every Missouri veteran that meets eligibility criteria will have reasonable access to a veterans' cemetery.[20] The MVC has five state veterans' cemeteries that are in operation at this time. These include Higginsville, Springfield, Bloomfield, Jacksonville and Ft. Leonard Wood. In addition to state veterans' cemeteries, veterans who meet eligibility requirements have access to two national cemeteries: Jefferson Barracks National Cemetery (St. Louis, Missouri) and Leavenworth National Cemetery (Leavenworth, Kansas).

PCG conducted analysis using demographics data from the USDVA of the 2018 and 2045 Veteran population in Missouri to determine the demand for veterans' cemetery use across the state and assess whether there is a need for the MVC to establish an additional cemetery in any part of the state. As part of this analysis PCG projected demand for all individuals eligible for interment services. This includes veterans, their spouses and eligible dependent children.[21]

The following four maps illustrate the veteran population in comparison to veterans' cemetery locations. Figure 11 and Figure 12 display the geographic coverage of each cemetery across the state within a 75-mile radius. According to the USDVA National Cemetery Administration (NCA) policy, new national cemeteries will be established in areas where at least 80,000 Veterans reside within a 75-mile radius and do not have reasonable access to a burial option in either a VA national or a VA-funded state Veterans cemetery.[22] PCG used this 75-mile radius as a guideline to assess current access to cemeteries for veterans across the state, and converted that radius into an estimated drive time of 1.5 hours to account for real-world road access and driving conditions. In Figure 13 and Figure 14 the geographic coverage of each cemetery across the state is represented by 30-minute drive time intervals.

[20] Eligibility for burial in a Missouri Veterans cemetery is the same for a national cemetery. The complete list of eligibility criteria for Veterans, spouses and dependents is outlined on the National Cemetery Administration website. https://www.cem.va.gov/burial_benefits/eligible.asp

[21] In addition to Veterans, spouses who are currently legally married, dependents under 21 years of age or 23 years of age and pursuing full-time course instruction at approved educational institution and unmarried adult children that are of any age but became permanently physically or mentally disabled and incapable of self-support before reaching age requirements of dependents, may choose to be interred in a state Veterans cemetery.

[22] https://www.cem.va.gov/cem/docs/factsheets/newcemdev.pdf

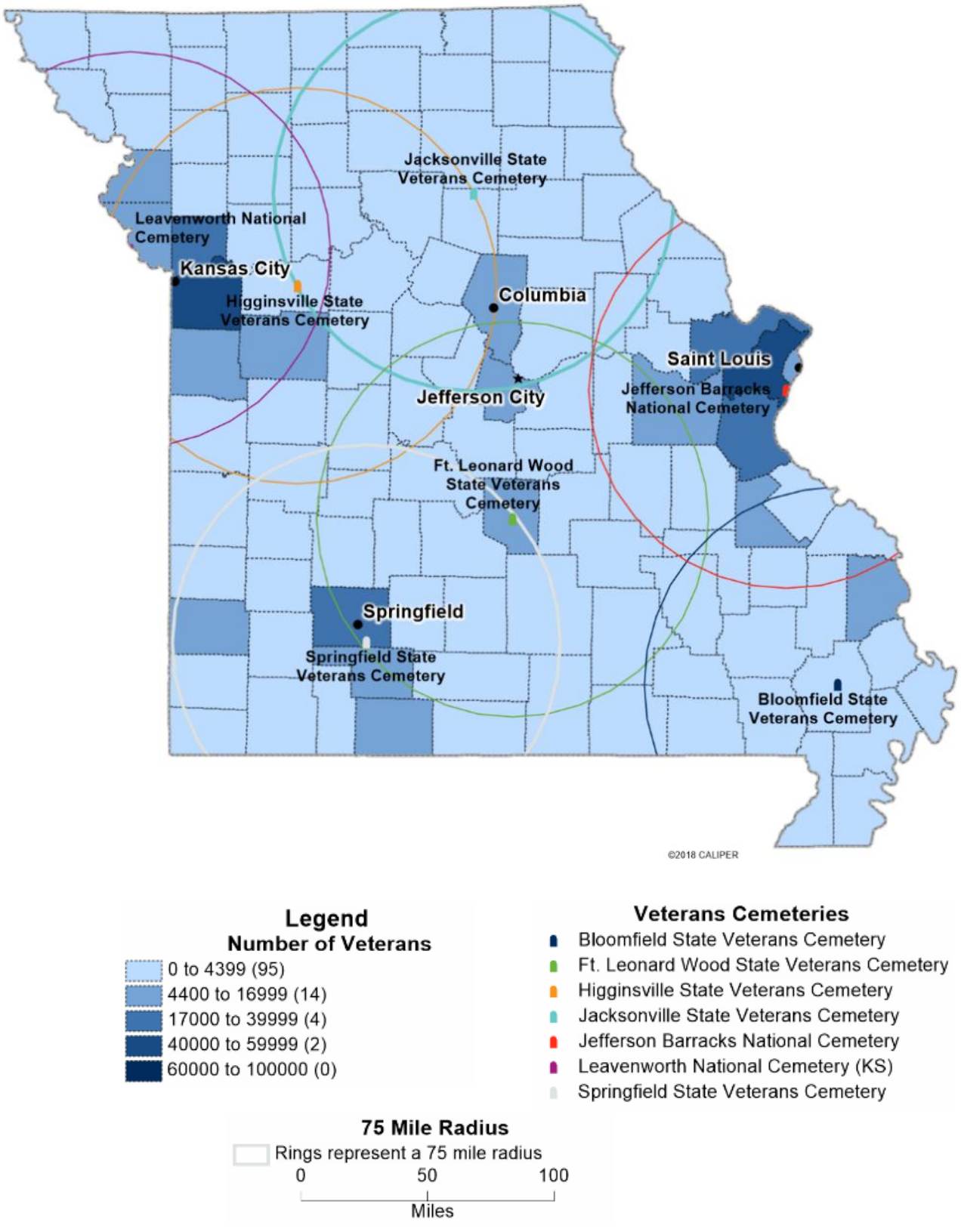


FIGURE 11: VETERAN PROJECTION FOR SEPTEMBER 30, 2018 (75 MILE RADIUS)

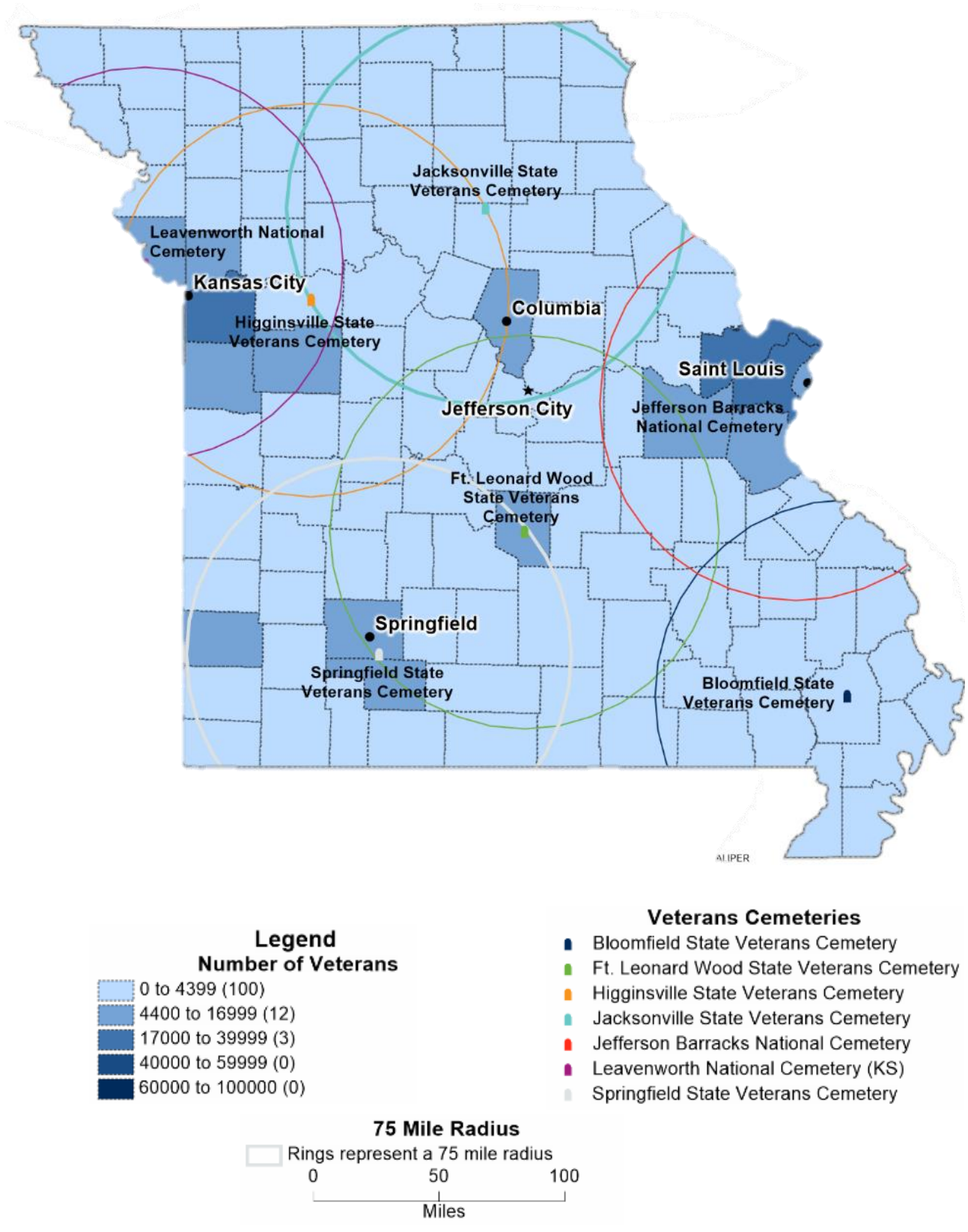


FIGURE 12: VETERAN PROJECTION FOR SEPTEMBER 30, 2045 (75 MILE RADIUS)

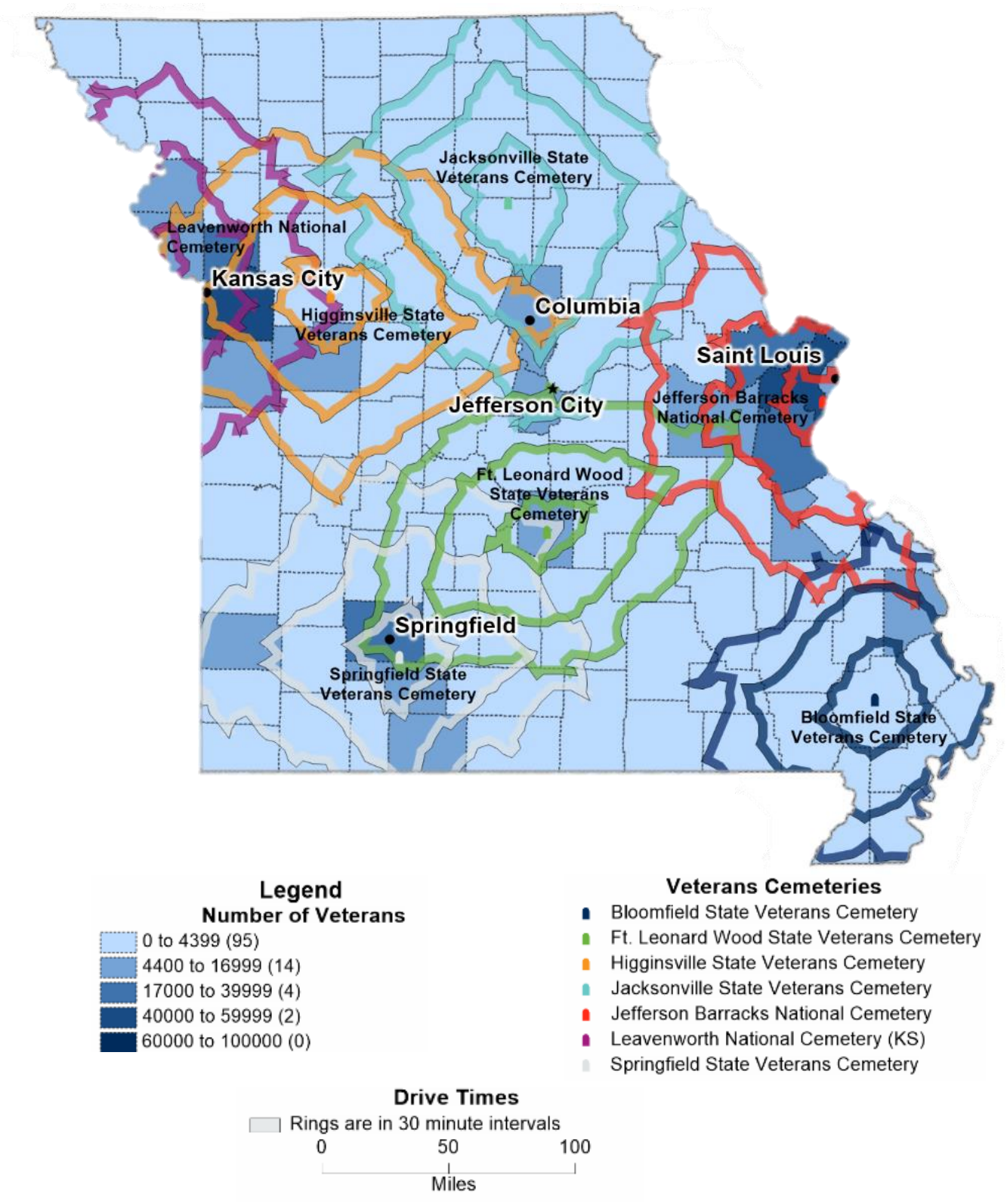


FIGURE 13: VETERAN PROJECTION FOR SEPTEMBER 30, 2018 (DRIVE TIME)

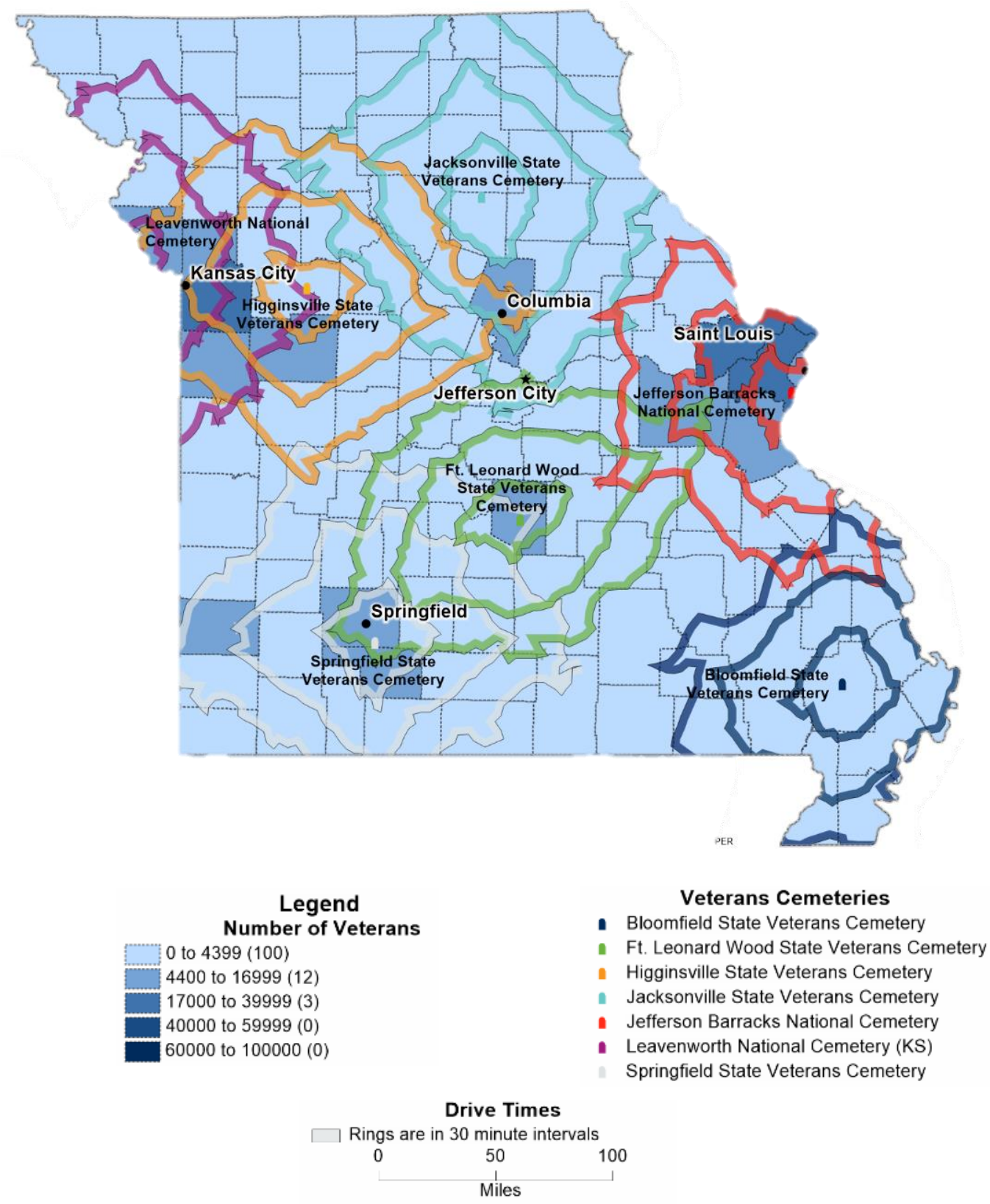


FIGURE 14: VETERAN PROJECTION FOR SEPTEMBER 30, 2045 (DRIVE TIME)

PCG calculated the projected veterans' cemetery demand using demographics data published by the USDVA on the 2018 and estimated 2045 veteran population. The NCA estimates that 20% of veterans choose to be interred in a state or national veterans' cemetery.[23] PCG applied that percentage to the total change in veteran population to ensure a conservative estimate on projected cemetery demand. The change in population was calculated by subtracting the estimated 2045 population from the estimated 2018 population. The projected non-veteran cemetery demand was calculated using the current veteran to non-veteran average ratio across all cemeteries of 2.58 provided by MVC. This ratio means that for every 2.58 veterans interred at a state veterans' cemetery there is one eligible non-veteran interred. Table 16 shows that 49,201 interments in a veterans' cemetery are projected as of 2045.

Table 16: Projected Cemetery Demand Across the State

2018 Estimated Veteran Population	434,373
2045 Estimated Veteran Population	257,088
2018-2045 Estimated Change in Veteran Population	**177,285**
Projected Veteran Cemetery Demand	35,457
Projected Non-Veteran Cemetery Demand	13,744
2018-2045 Total Projected Cemetery Demand	**49,201**

In July 2019, MVC provided PCG with the remaining capacity for each veterans' cemetery in the Missouri. The data was used to calculate a total of 90,991 developed in-ground and columbarium spaces available, with an additional 92,000 undeveloped in-ground spaces, across the state. The combined total capacity of both developed and undeveloped land as shown in Table 17 is 182,991 spaces. This total excludes any available spaces in national veterans' cemeteries where veterans may choose to be buried. Additionally, while the Higginsville and Springfield cemeteries have developed all of their current acreage, there is state-owned property adjacent to Higginsville and city-owned property adjacent to the Springfield cemetery that could potentially provide an option for expansion should MVC decide to pursue the purchase or lease of these properties.

Table 17: Remaining Capacity of Veterans Cemeteries Across the State

	Higginsville	Springfield	Bloomfield	Jacksonville	Ft. Leonard Wood	Statewide
In-Ground	31,304	34,564	7,924	7,210	5,317	86,319
Columbarium	1,174	2,577	40	192	689	4,672
Total Developed	**32,478**	**37,141**	**7,964**	**7,402**	**6,006**	**90,991**
Undeveloped In-Ground	0	0	12,000	31,000	49,000	92,000
Total Capacity (Developed and Undeveloped)	**32,478**	**37,141**	**19,964**	**38,402**	**55,006**	**182,991**

[23] https://www.ea.oit.va.gov/EAOIT/OpenData/docs/National-Cemetery-Administration-data_va_gov.pdf

RECOMMENDATION

PCG's analysis has determined that MVC does not need to develop a new veterans' cemetery at this time. Based on a conservative estimate of the population through 2045, MVC has an ample amount of developed veterans' cemetery capacity. As shown in Table 18, in 2045, 46% of total developed cemetery capacity across the state will be available. Should there be a need for additional veterans' cemetery capacity, MVC should first pursue building out undeveloped acres based on the area of the state with the most demand. In 2045, 73% of cemetery capacity, both developed and undeveloped, will be available across the state.

Table 18: Percent of Remaining Cemetery Capacity as of 2045

	2019 Remaining Cemetery Capacity	2045 Projected Cemetery Demand	2045 Remaining Cemetery Capacity (%)
Total Developed	90,991	49,201	46%
Total Capacity (Developed and Undeveloped)	182,991	49,201	73%

In addition, the vast majority of the veteran population, as shown in Figure 11: Veteran Projection for September 30, 2018 (75 Mile Radius) and Figure 12: Veteran Projection for September 30, 2045 (75 Mile Radius), is within the 75-mile radius of a veterans' cemetery, which is used as a guideline for access by the National Cemetery Administration. In Figure 13: Veteran Projection for September 30, 2018 (Drive Time) and Figure 14: Veteran Projection for September 30, 2045 (Drive Time), it is also evident that the majority of the veteran population is within a drive time of one hour and thirty minutes of a veterans' cemetery. Counties outside of either the mile or time radius are estimated to have less than 4,400 Veterans living within that county. Therefore, using state resources to build an additional cemetery to expand geographic reach would have a smaller impact on the veteran community across the state.

RISKS & MITIGATION

If MVC moves forward with PCG's recommendation not to establish an additional Veterans cemetery, there is the potential for the following risks.

1. PCG used a conservative estimate of the veteran population to calculate the demand versus capacity, however there is the potential risk that the demand of veterans' cemetery use could change over time based on population changes and increased interest of veterans. It is anticipated that as new cemeteries open there will be increased interest for interment in a Veterans cemetery. Considering that as of 2045, 46% of developed cemetery capacity will remain, it seems unlikely that the change in demand would be greater than the remaining developed cemetery capacity at that time. However, if so, this risk could be mitigated by building out undeveloped acres of land where available.
2. Given that currently some veterans' cemeteries have more remaining capacity than others, there is the potential risk that one or several cemeteries might reach full capacity more quickly than other cemeteries. This risk could be mitigated by building out undeveloped acres of land where available and directing veterans to utilize the next closest cemetery. As noted previously, land may be available for acquisition near both the Higginsville and Springfield locations to address this issue if needed.

With minor risks that could be mitigated with relatively minor impact, the potential benefits and cost savings outweigh the potential risks and therefore supports the recommendation not to proceed with establishing an additional veterans' cemetery at this time.

COSTS & BENEFITS

Though the federal government can provide up to one hundred percent of the development costs for an approved establishment of a new cemetery and can provide for operating equipment, the administration, operation and maintenance of a VA-supported veterans' cemetery is solely the responsibility of the state.[24] Selecting not to develop a new state veterans' cemetery will eliminate any administrative and operational expenses that the state would incur. Operational costs include Personnel Services, Fringe Benefits, Utilities, Depreciation, Equipment and Expense. Data on the total operational costs of each cemetery provided by MVC for Fiscal Year 2019 is displayed in Table 19: FY19 Operational Costs by Cemetery. Operational costs vary across the cemeteries due to differences in geographic location, number of acres and number of interments among others. By not building an additional cemetery, MVC will avoid spending $661,783 annually, which is the average operational cost across all cemeteries within the state. In addition to the financial benefits, MVC will also benefit by reducing the level of administrative effort that would be necessary to plan and build out an additional cemetery.

Table 19: FY19 Operational Costs by Cemetery

	Higginsville	Springfield	Bloomfield	Jacksonville	Ft. Leonard Wood
Annual Operational Cost	$654,125	$781,045	$793,824	$555,838	$524,081
Average Annual Operational Cost	**$661,783**				

[24] https://www.cem.va.gov/cem/grants/index.asp

VETERAN SERVICES OFFICERS

OVERVIEW

PCG interviewed several MVC Veteran Services Officers (VSOs) over the course of this project. A summary of the information gathered is included in Table 20; additional information, including specific interview questions, is included in Appendix A. The main focus of VSOs is helping veterans file claims with the VA for benefits, although they are often asked for assistance in other areas as well, including financial assistance for bills and housing costs.

VA claims submitted by MVC VSOs in SFY 19 or earlier resulted in $315 million in awards to Missouri veterans in 2019 alone.

According to MVC, the claims submitted by their VSOs during state fiscal year 2019 and all previous years combined directly resulted in the award of $315 million in federal funds to Missouri residents in 2019. For every $1 spent on the VSO program (which includes Rent, Utility, Fringe Benefits, Personnel Service and Equipment/Expense), $112 was contributed to the state's economy in the form of federal benefit dollars to veterans or their beneficiaries.

In addition to their claims-focused work, VSOs are able to assist veterans with access to a wide array of additional benefits offered by the state. In a recent study by the Center for New American Security, Missouri was identified as offering the second highest number of benefits in the nation to veterans. Missouri offered these benefits across the 40 different subcategories, more than any other state. These subcategories include education, employment, state services, as well as legal and advocacy assistance.[25]

Table 20: VSO Outreach Interviews

Topic	Summary of Responses
Caseload size	• Contacts could range to the 100s each month • May take 20-30 new cases per month • Tracking 50-100 ongoing claims through 6+ month process
"Typical" day	• 70-80% of work is related to claims for VA pension or disability • Supervisors have similar duties to VSOs as well as additional administrative tasks • Research, paperwork, and walk-ins take up significant amounts of time • Some offices have switched to "appointment only" but don't turn walk-ins away
How do Veterans connect with VSOs?	• First contact is typically phone call; some offices receive as many as 60-100 calls per day • Many referrals from the community – VSOs do significant outreach to local events
Services and resources available	• Referrals to community organizations • Hotline to VA for VSOs • MVC Outreach Coordinator • VBMS access (supervisors and some others) to check status of appeals and claims directly with VA • Claims QA check by MVC staff located in VA Regional Office

[25] Center for a New American Security, *From Sea to Shining Sea: State Level Benefits for Veterans*, November 2019, https://www.cnas.org/publications/reports/from-sea-to-shining-sea.

Table 20: VSO Outreach Interviews	
Areas where most assistance provided	• Claims work / financial assistance from the VA • Survivor benefits • Referrals to legal services and other community resources
Challenging requests / activities	• Compensation claims and finding supporting evidence • Issues with ID cards • Requests to find attorney to pursue further appeal • Assistance with housing and household bills • Billing issues with VAMCs • Services for non-service-connected Veterans
Other resources that would be helpful	• More / clearer guidelines on emergent care payments • VBMS access for all VSOs • Training around the fact-finding necessary to support claims • Clear messaging to veterans and community organization about the role of the VSO • Prioritization around outreach activities, to make sure they are efficient in terms of veterans reached

Discussions with MVC leadership indicate that they are aware of both the challenges and opportunities presented here and have already taken steps to mitigate the challenges where possible. This includes reaching out to USDVA partners, legal services agencies, and other stakeholders to identify additional resources, and conducting outreach to veterans and in the communities that VSOs serve.

RECOMMENDATION

Unlike many other states, Missouri does not allocate VSOs at the county level, but apportions them across the state according to need. This has resulted in the state having a lower number of VSOs than other states that assign them by county or municipal level. According to USDVA data for FY 2018, Missouri ranks 15th in veteran population, yet ranks 28th in the amount of compensation and pension dollars per veteran.[26] States with similarly sized veteran populations, like Indiana and Colorado, have twice as many VSOs as Missouri. While more VSOs doesn't translate to higher per veterans compensation and pension levels in every state, given the impact of the work of Missouri's VSOs on veterans and the multiplier effect of the investment in these positions on the state's economy, MVC should invest in additional VSOs as the budget allows.

[26] https://www.va.gov/vetdata/Expenditures.asp

ADULT DAY HEALTH CARE (ADHC)

OVERVIEW

Adult Day Health Care (ADHC) is a program that veterans can attend during the day for social activities, peer support, companionship, and recreation. The program is for veterans who need help with activities of daily living; generally, health services, provided by nurses, therapists, and others, are available.

At present, only three states (and only specific facilities in each of these states) are currently providing ADHC using funding from the USDVA: New York, Minnesota and Hawaii. The table below includes an overview of the services in these states that will allow for a comparison between the three.

Table 21: States Providing ADHC

Topic	New York	Minnesota	Hawaii
Daily Census	37 (Avg)	25 (Avg)	21 (Max)
Funding Sources	• VA • Self-Pay • Medicaid	• VA • Self-Pay • State Appropriations	• VA • Self-Pay • Some Medicaid and Managed Care Organization (MCO) funds
Space / Location	• 1 location • Certified for 50 • Long Island State Veterans' Home at Stony Brook University	• 1 location • Certified for 35 • Building 4 on the Minneapolis Veterans' Home Campus	• 1 location • Certified for 32, limited to 24 based on number of bathrooms • Hilo Medical Center
Costs	• Receives 65% of cost of full day care **($336.70)** for a veteran with a service-connected disability of 70% • Private pay cost of **$184.92** per day • Medicaid reimbursement rate is $144 per day	• Receives 65% of cost of full day care **($239.70)** for a veteran with a service-connected disability of 70% • Private pay cost is per diem plus $20 copay (current total **$107**) • The full cost of care is estimated at $225 per day for ADHC • The full cost of care is **$368.77** per day for nursing home care • The state receives **$500k funding from state legislature each year** to cover the cost of services (demonstrated cost savings to the state of up to $3.5m / year)	• Receives 65% of cost full day care **($312)** for a veteran with a service-connected disability of 70% • Full costs of care have been **$200** a day per veteran • No copay charge for service-connected veterans; basic copay is **$65** per day for non-service-connected veterans and $90 per day for spouses

Table 21: States Providing ADHC			
Topic	**New York**	**Minnesota**	**Hawaii**
Outreach and Enrollment	Relationship with VA hospital social workers	Initially, developed a brochure and conducted outreach activities	Unknown – little to no outreach at VA-level
Management	State staff	State staff	Contract

More specific details from each state can be found in the tables below.

Table 22: Long Island State Veterans' Home, New York	
Facility Overview	The Long Island State Veterans' Home in Stony Brook, NY is the only facility in New York to offer Adult Day Health Care. The program has been in existence since 1995 and has undergone many changes over the years. Presently, the state manages their own facility with state staff using a ¾ FTE model with nursing assistants who cover the hours of 8-4 and are paid for 6.5 hours.
Financials	The program is funded via Medicaid, private pay and the VA. In addition, the state: • Receives 65% of cost of full day care **($336.70)** for a veteran with a service-connected disability of 70% • Has a **private pay cost of $184.92** per day • Has a **Medicaid reimbursement rate is $144** per day
Facility / Space	The program retrofitted current space to accommodate the addition of the ADHC "facility" and submitted a grants waiver to have shared space with long term care. It is licensed for up to 50 veterans a day, but the facility footprint only allows for 43 veterans. There are currently 80 total enrollments including spouses in the program; they average 37 veterans a day with a 12% absentee rate. The facility has its own recreation staff, but also relies heavily on volunteers. The formal program runs for 6 hours each day (from 9 am to 3 pm) and includes: breakfast, one to two formal activities starting at 10 am, lunch from 12-1 pm, and afternoon programming that includes a walk / stroll program and trivia. The facility is also prepared with alternative tabletop activities for those who don't want to participate, including drawing, puzzles, cards, coloring books, painting, iPads, games, etc. Participants can also participate in programs / services offered in the main building, such as haircuts, dental care, podiatry, optometry and rehab services, and bathing / showers.
Transportation	The state contracts with an outside ambulette vendor for door-to-door transportation. This costs participants $32 each way, assuming a round trip ride. They also offer group rides because they have a clear understanding of the exact geography that their population serves. One of the first things they did was draw out their catchment area. The facility does not have a no-show policy and their transportation vendor does not charge for no-shows.

Table 22: Long Island State Veterans' Home, New York	
Outreach and Enrollment	The outreach and enrollment effort with the waiting list, talking to each one of those folks, assessing need, and looking for service-connected veterans. The program accepts honorably discharged veterans from all branches of the United States Armed Forces. Admission to the ADHC program is open to all veterans regardless of period of service, service-connected disability or location in which the veteran served. They also accept the spouse or widow of qualifying veterans, as well as Gold Star Parents, who require adult day health care. With the introduction of Public Law 115-159, this home has seen more veterans versus non-veteran (spouses and widows) in the program. Thirty-eight (38) percent of their Vietnam veteran population are part of the 70% or greater service-connected disabled category, which has seen a significant influx compared to prior years.
Competition	The state looked closely at the market in each one of areas where they had a state facility, looking closely at other adult day care programs in the area (are they full, are they funded, is it successful, etc.). They have a very competitive market across the state but found that the Long Island site made sense. It is worth noting that the VA has a contract program that lets veterans who qualify go to competitors at no cost to the veteran.

Table 23: Minnesota Veterans' Home, Minneapolis	
Facility Overview	Minnesota currently has five veterans' homes and provides ADHC on their Minneapolis campus. The Adult Day Center provides a veteran based community and includes a full range of therapeutic and rehabilitation health care services. Admission requirements don't change based on service-connected disability reimbursement and the facility provides at least 6 hours of care that includes a full breakfast, lunch and afternoon snack. Participants range from 66 to 97 years old.
Financials	The program is funded via state appropriations, private pay and from the VA. In addition: • The state receives 65% of cost of full day care **($239.70)** for a veteran with a service-connected disability of 70% • Their private pay cost is per diem plus $20 copay (current total **$107**) • The full cost of care is estimated at $225 per day for ADHC • The full cost of care is **$368.77** per day for nursing home care • The state offers veterans care two times / week without a copay charge • The state receives **$500k funding from state legislature each year** to cover the cost of services (demonstrated cost savings to the state of up to $3.5m / year) • Minnesota does take Medicaid and elderly waiver • Recent bill now allows veterans with a 70% service-connected disability to get a higher per diem for ADHC • Revenue cannot be more than 50% of costs because of how the program is regulated Government loans used to rehabilitate the building require the ADHC program to stay open for 20 years.

Table 23: Minnesota Veterans' Home, Minneapolis	
Facility / Space	Minnesota currently meets the 100 square feet requirement per veteran and is licensed for up to 35 veterans per day, but for space and staffing reasons, they try to keep the daily census to 25. More specifically, they currently have 40 veterans enrolled and daily attendance is 15-25 per day. For renovations of existing space, the program received a $2 million loan from the government. The facility is open from 8 am – 4:30 pm.
Transportation	The state contracts with a local transportation provider (Metro Mobility) to provide transportation for veterans. The cost for this ranges from $3.50-$4.50 each way and is paid by the participant.
Outreach and Enrollment	Minnesota built their program from scratch, developing a brochure and conducting outreach activities. They currently accept family members / spouses of veterans or Gold star parents. They also include the transportation time in the 6 hours so recipients can have a shorter day if it is needed. The Veteran must have an honorable discharge, serving at least 181 consecutive days of active duty. The Veteran must also be a Minnesota resident or have service credited to Minnesota to quality for the program.
Competition	Minnesota ADHC facilities have significant competition from the VA hospital who has their own ADHC in close proximity. The state doesn't feel competition from private facilities because families are looking specially for veteran and male-dominated services.

Table 24: Hawaii Veterans' Home	
Facility Overview	The Yukio Okutsu program initially opened in December 2006, and then closed in 2007 after a few months due to lack of enrollment / reimbursements. It re-opened in 2011 although it has been "losing money" each year.
Management	Managed through a contractor, the governor agreed to fund the state portion so it would be self-sustaining. The use of Avalon Health Care to operate the facility allows them to take some steps that the state couldn't do on its own, like restricting access to veterans who are able to offset their share costs. Staff that are operating the program are Avalon employees, not state employees; metrics in the contract ensure that performance targets are clear. • Fewer political concerns re: charging per diem fees or selection criteria • Less risk for catastrophic events borne by state • State employee works closely with contractor to provide oversight
Financials	The ADHC program receives some Medicaid funds, but most payments are through private pay and Managed Care Organization (MCO) payments. In addition: • The State receives 65% of cost full day care **($312)** for a veteran with a service-connected disability of 70%; new per diem rate is helping them breakeven • Full costs of care have been **$200** a day per veteran • No copay charge for service-connected veterans; basic copay **is $65** per day for non-service-connected veterans and $90 per day for spouses • Most veterans don't have Medicaid or private insurance to cover the program; some veterans have coverage with MCOs that will pay for program Billing to the USDVA is based on a nursing home spreadsheet, which has shortcomings from an ADHC standpoint.

Table 24: Hawaii Veterans' Home	
Facility / Space	The current building was not constructed with ADHC specs in mind. They have the square footage for 32 participants but are limited to 24 by number of bathrooms (3, but the ratio is 1:8). A fourth bathroom will need to be built to fully enroll 32 participants. They found that people will not relocate for ADHC like they do for skilled nursing, so location is key. The state had to include transportation at no extra cost just to encourage enrollment.
Transportation	Staff members (CNAs) are trained as drivers and are currently providing transportation to participants in vans owned by the facility. Transportation routes are limited to 25 miles and it is a highly localized program. The cost of the transportation is included in the rate and billed as a "freebie" to encourage participation in the program.
Outreach and Enrollment	Currently, 21 participants are enrolled; their maximum capacity is 24 participants. They receive little / no assistance from VA on outreach. While doctors must assert that the veteran needs care, there aren't strict standards around this. For enrollment, they verify if participant is a veteran, DD-214, holds a marriage certification, meets medical criteria for nursing level of care (101-SH, 101-EZ documents) with a focus on ADLs, dementia, etc. *They are cautious with enrolling participants with mental health concerns because not all areas of the program are secure and participants are able to move around the area freely.* The waiting list for spouses is quite full, with more spouses interested than vets. Only 25% of population can be spouses or gold star family members. Going over 25% can lead to findings when there is a review / audit of the facility.
Competition	The facility has significant competition from other adult day health care program in the area. Regular ADHC programs that are not medically supervised are the main competition.

PCG's recommendations for moving forward with an ADHC facility are based on the following key factors, which were developed from our reviews of the above state ADHC facilities and discussions with facility leadership.

Management	Based on what other states are doing for both facilities as well as adult care services, there are two options for management of an ADHC program: (1) to use state staff or (2) to use contract staff. There are several challenges and advantages to each that we reviewed including the cost, the ability of Missouri to add additional state FTEs, and the political implications of contracting out the care of the state's veterans. Because MVC's veterans' homes utilize state staff, PCG would recommend that the ADHC program do the same, at least at the outset.
Financials	Missouri should understand that, like many health care and supportive services the state provides for veterans, ADHC is not a money-making venture. It will be worthwhile for the state to frame the move forward with ADHC in the context of long-term cost savings and outcomes that keep people safely in their homes for longer. Several of the states we talked to are able to demonstrate savings this way that may be of use to Missouri. In addition, when it comes to paying for services, we considered the below factors: 1. Utilization of Medicaid reimbursement. The published reimbursement rate for ADHC is $2.29/15 min per unit. Being able to bill Medicaid would greatly

	enhance the revenue that the state can obtain, over and above per diems from the VA. 2. The political will to impose a per day charge on ADHC services, or for transportation costs. Some states charge non-veterans (such as spouses) but not veterans themselves; others charge after a certain number of days (MN, for example, provides two fee-free days per week).
Location	Each of the states interviewed co-located their ADHC program with a state veterans' home, allowing them to leverage staff and equipment when possible. Other important factors are included in the location matrix in the recommendation section, but each of the other states stressed that there must be potential users in the area near the chosen site. Our recommendation is to start in one area with a significant veteran population, then expand to other locations as it makes sense and need arises.
Space	If Missouri is planning on using VA money to make renovations to existing space, that will require having 75% veterans in the program; if only Missouri dollars are used, that requirement drops to 50%. It is worth noting that in the beginning, New York struggled to meet the 50% threshold.
Programming	The state will have to pay close attention to the population when it comes to space needs and programming. For example: • A younger population needs more space. People move around more, need more recreational activities, and are generally more independent. • Considerations should be made for Alzheimer / Dementia patients who will need quiet. • Baths and clinical services may be needed / desired for some populations. • Patients with a mental health diagnosis may need additional services. Missouri should also consider meeting rooms, locating as much on the ground level as possible, and access to an outside drop-off/pick-up, sheltered entrance.
Outreach and Enrollment	The state will need to work to nurture relationships at VA and hospital facilities to create a pipeline for referrals.
Competition	We included competition as a factor in making our recommendations, looking at the array of ADHC providers in the vicinity of the current Missouri veterans' homes.

RECOMMENDATION

The creation of an ADHC facility for veterans in Missouri is the best way for the state to take advantage of available funding to provide additional services to veterans who may have medical needs but do not require 24-hour skilled nursing care. The cost for startup is significantly lower, and while fewer veterans can be served at one time, there is strong potential for expansion to multiple locations across the state.

PCG's research into the other ADHC programs currently operated by state departments of veterans' affairs helped identify some of the challenges that a new facility can face; many of these are included in this section. We have also used this information to create a matrix to identify the best location for this facility. In New York, Minnesota, and Hawaii, the ADHC facility is generally near to a veterans' home, often on the same campus. The quickest way to move forward would be to repurpose some available space at one of the current homes, and leverage the materials, supplies, and other economies of scale that come with a larger facility.

In developing the geographic location selection matrix detailed in Table 25 below, PCG considered the following factors relating to each of the seven existing veterans' homes:

1. **Current occupancy rate** – A lower occupancy rate indicates that there may be additional unused space available that could be converted to another use, such as ADHC.

2. **Available ADHC slots in the county where the home is located and adjacent counties** – PCG reviewed the total number of private-market ADHC slots and sorted them by county. For these purposes, adjacent generally refers to counties that directly border the county where the home is located.

3. **Waiting list applicants, as of October 1, 2019, determined to need 24-hour skilled nursing care –** The number of applicants on the waiting list assigned to an existing home who have been determined to require 24-hour skilled nursing care.

4. **Veterans aged 65 or older in the county –** The number of veterans aged 65 and up indicates the potential need for additional services, which do not necessarily need to be 24-hour skilled nursing care beds.

5. **Veterans aged 65 or older in adjacent counties –** This also indicates the potential for service needs in the general area of the existing home.

6. **Unemployed members of the workforce in the county and adjacent counties –** This indicates that there may be a sufficient workforce to staff a new ADHC facility. Because staffing needs for an ADHC are so much lower than a skilled nursing facility, this isn't as large of a concern for ADHC, but is still an important factor.

7. **Beds displaced –** Whether or not beds at a current facility would need to be taken off-line to accommodate the space needed for the ADHC program.

8. **Staff in place –** Discussions with MVC staff indicated that one current veterans' home already had sufficient additional employees to begin staffing an ADHC program.

Each of the current veterans' homes were ranked across each of these categories, with a 1 or 0 indicating most appropriate for ADHC, and 7 least appropriate. Each category ranking was added together, with the lowest total score indicating the best choice to site an ADHC program. As Table 25 below shows, PCG recommends the St. Louis home as the best place to implement an ADHC program.

Table 25: ADHC Location Selection Matrix

Note: Figures below represent ranking in each category against other Missouri state veterans' homes.

Home	Current Occupancy Rate	ADHC Slots in Current and Adjacent Counties	Need SN Applicants on W/L	Vets 65+ in County	Vets 65+ in Adjacent Counties	Unemployed Workers in County and Adjacent Counties	Beds Displaced? (Yes = 1, No = 0)	Staff in Place? (No = 1, Yes = 0)	Total Ranking Score	Overall Rank
Cameron	3.5	6	4	6	3	2	1	1	26.5	4
Warrensburg	5	5	1	3	4	3	1	1	23	2
Mount Vernon	3.5	4	3	5	2	4	1	1	23.5	3
Mexico	7	1	2	7	5	5	1	1	29	5.5
St. James	1	2	7	4	6	7	1	1	29	5.5
Cape Girardeau	6	3	6	2	7	6	1	1	32	7
St. Louis	2	7	5	1	1	1	0	0	17	1

As noted above, PCG focused the review of potential locations on current MVC veterans' homes, due to the reduced costs and start up time, as well as the ability to leverage resources from one facility to another. There are other parts of the state that, but for these factors, would also be in consideration for the placement of an ADHC program. Although they cannot be prioritized as highly as those sites included in Table 25 due to the additional cost that the state would incur to build a new facility from scratch, rather than renovate or expand a current facility, they may be revisited in future planning exercises. These locations include the following:

- Jackson County and the Greater Kansas City area
- Cole County and the Jefferson City area
- Jasper and Newton Counties, and the Joplin area
- Franklin County or Jefferson County, outside of St. Louis
- Taney County, possibly in the Branson area
- Butler County and the Poplar Bluff area

RISKS & MITIGATION

PCG's outreach to the other states that administer ADHC programs for veterans revealed a few risks that MVC should be aware of prior to moving forward. First, enrollment was an issue in some places. Unlike 24-hour skilled nursing care, where a veteran resides at the facility, ADHC participants must travel to and from the facility, and it is unlikely that anyone would permanently relocate to attend. To mitigate this concern, it is important that there is a large pool of veterans in a relatively compact region.

Another potential risk is funding. Until recently, there was a single, relatively low, per diem rate for ADHC. In 2017, the per diem rate for veterans with a 70% or higher service-connected disability was increased substantially. However, many states are justifiably concerned about selecting certain types of veterans over others; some don't even collect service-connected disability information at all. This makes it hard for states to take advantage of this higher per diem rate. It may not be possible to completely mitigate this issue, but MVC could be sure to explicitly

state in its outreach materials that veterans of any service-connected disability level are welcome to apply or participate in the ADHC program.

Although discussed above, transportation was a concern raised by other states that warrants additional mention. In order to ensure consistent attendance, it is recommended that the state fund, or heavily subsidize, transportation services. In New York, the ADHC program has factored a transportation contract into its annual operating expenses, while Minnesota is able to leverage a low-cost senior transportation program to provide rides for participant, although it does come with a small out-of-pocket fee to the veterans who use it. MVC should be sure to factor this in, whether it requires procuring services at a reduced per-ride fee or determining a way to leverage existing public transportation services.

COSTS & BENEFITS

Although significantly less than the costs of building and operating a new, standalone skilled nursing facility, moving forward with an ADHC facility will come with some costs to MVC. One potential mitigating factor in terms of cost is the ability of MVC to utilize some existing space at the St. Louis Veterans' Home to accommodate this program; that has been factored into the cost estimates in this section. In order to develop these estimates, PCG researched space and square footage requirements, staffing requirements for ADHC, and other costs that would factor into the development or operations of this facility. In many cases, both the USDVA and the State of Missouri have regulations around ADHC; in almost all cases, the USDVA requirements are more stringent, and have been used here.

Space Requirements and Construction Costs

PCG reviewed the requirements for square footage in an ADHC facility from the Missouri Department of Health and Senior Services[27] (DHSS) and USDVA.[28] Based on this review, the following elements are required in an ADHC facility:

Square Footage: 100 sq. ft per participant; optimal is 128.5 sq. ft per participant

Additional Required Elements:

- Multipurpose room
- Kitchen area
- Exam / medication room
- Quiet room (including 1 bed)
- Bathing facilities
- Toilet facilities (1 per 8 participants, no more than 40 ft from program areas)
- Storage
- Interview room
- Reception area
- Outside space
- 1 chair per participant
- Sufficient table space for all participants to be served meal at same time

PCG used this information, along with the RSMeans cost estimating system, to generate an estimate of the costs to create an appropriate space for an ADHC at the St. Louis Veterans' Home. RSMeans is an internet-based software package that collects and compiles national construction and renovation cost data for a wide variety of building types. In addition to providing up-to-date cost per square foot estimates that take into account the design, materials, and labor costs for a specific building type of a given size, RSMeans also publishes a set of city cost indexes (CCI) that allow for a base cost per square foot to be appropriately modified by locale to adjust for differing costs of living, land value and labor costs. This system incorporates indices to adjust costs to the local market, ensuring an estimate that reflects the costs of doing business in St. Louis, rather than costs that reflect an average figure across the state or country.

PCG's recommendation is to begin with a program that can accommodate about 40 participants, with the knowledge that they will all rarely, if ever, be attending the program at the same time. The USDVA's optimal square footage estimate calls for 5,140 square feet to accommodate 40 participants; to ensure a conservative estimate, PCG used the "Net-to-department gross factor" (NTDG) that the USDVA uses as to calculate space for

[27] https://health.mo.gov/seniors/nursinghomes/pdf/ADCProgramManual.pdf, pgs. 87-93.
[28] https://www.govinfo.gov/content/pkg/CFR-2016-title38-vol2/pdf/CFR-2016-title38-vol2-part52.pdf.

the "small house model."[29] Applying this factor, which is set at 1.6, results in total square footage of roughly 8200. The RSMeans cost estimate to construct a building of this size is $1,516,287. This includes labor, contractor fees, and architectural fees, as well as basic standard equipment to outfit a senior assisted living facility, which should be roughly equivalent to that needed for ADHC, for the purposes of this estimate. This does not include all of the additional furniture that will be required. A complete explanation of this cost can be found in Appendix B.

There are a number of factors that could alter this cost estimate. In MN, the cost for renovation of an existing building was closer to $2 million; however, that was for a very old, three-story facility. The current state of the St. Louis home could also impact how much this construction will cost, as well as any additional requirements of the state procurement process. Assuming that federal 65% matching funds are utilized, the state's contribution to the construction necessary for the ADHC facility would be $530,700.

Staffing Requirements

USDVA regulations call for a staff to participant ratio of 1 to 4 or 1 to 6, depending on the needs of the program. Missouri DHSS regulations call for a 1 to 8 ratio, so PCG has utilized a 1 to 6 staff to participant ratio for the purposes of this estimate. In addition, the facility must have a Registered Nurse (RN) on duty at all times, and is required to have access to the following staff on either a part time or consultative basis:

- Dietitian
- Physician as needed
- Social Worker
- Rehabilitation Therapist
- Therapeutic Activity Therapist
- Pharmacists
- Medical director (who should be a primary care physician)

At the time of this report, MVC has currently allocated enough FTEs to the St. Louis Veterans Home to staff an ADHC facility. It is also very likely that MVC will be able to leverage some of the specialized staff currently at the St. Louis Veterans' Home to meet staffing requirements beyond direct care staff, but for the purposes of this estimate, PCG has included the cost for salaries and benefits for these full or partial FTEs. In calculating ongoing operating costs, PCG used a "cost per day" figure of $200 per participant that was developed after speaking with administrators from the 3 existing ADHC facilities. That figure is assumed to include staffing to meet the 1 to 6 ratio, and administrators did not report any significant additional staffing costs to meet USDVA requirements that were not included in this figure.

Transportation

USDVA regulations require that an ADHC program provide or contract for transportation that is available to all participants.[30] Those participants who chose to provide their own transportation are free to do so, but a program-provided option must be available. The states with current ADHC programs each take a different approach to providing transportation. Minnesota utilizes a local shared-ride public transportation service that provides rides for the disabled, which comes with a small fee to participants. New York has contracted out to a private transportation company to provide rides to and from the program, at a cost of $32 each way. Hawaii has its own fleet of vans and drivers and does not charge any additional fee to participants.

Because of the difficulties that states had in recruiting participants when their programs started, it is recommended that MVC include costs for transportation in its costs to operate this program, to remove what could be a significant barrier to participation. If possible, the state should look to leverage an existing shared-ride program and subsidize any additional costs; contracting out services also provides greater flexibility in terms of scaling the program up (or down) depending on demand.

[29] https://www.cfm.va.gov/til/space/spChapter106.pdf.
[30] See 38 CFR 52.220. https://www.govinfo.gov/content/pkg/CFR-2016-title38-vol2/pdf/CFR-2016-title38-vol2-part52.pdf.

Potential Estimated Operational Costs

Assuming 40 total slots and a projected daily census of 30, Table 26 estimates revenues and expenses for varying combinations of veterans with 70% or higher service-connected disabilities and differing levels of financial contributions from non-service-connected veterans. Based on the anticipated costs to operate the ADHC program and transport veterans to and from the facility, a fairly significant daily copay will be required for the program to break even, unless a large number of 70% SCD veterans choose to participate. While the average cost for adult day care in Missouri is around $80 per day,[31] the range of private pay rates for the three other states that operate an ADHC program using USDVA grant and per diem funds runs from $65 through $184 per day. These peer states are a better comparison, as there is more standardization of required tasks for USDVA-funded ADHC than for private-market adult day care programs.

Table 26. Cost and Revenue Estimates

Number of Veterans > 70% SCD	Daily Copay (for <70% SCD veterans)	Projected Per Diem Daily Revenue	Projected Annual Revenue (copay + per diem)	Total Cost for Care + Transportation	Cost After Revenues
0	$25	$2,622.60	$876,876.00	$1,872,000.00	$995,124.00
5	$25	$3,515.76	$1,076,596.95	$1,872,000.00	$795,403.05
10	$25	$4,408.92	$1,276,317.90	$1,872,000.00	$595,682.10
0	$50	$2,622.60	$1,071,876.00	$1,872,000.00	$800,124.00
5	$50	$3,515.76	$1,239,096.95	$1,872,000.00	$632,903.05
10	$50	$4,408.92	$1,406,317.90	$1,872,000.00	$465,682.10
0	$75	$2,622.60	$1,266,876.00	$1,872,000.00	$605,124.00
5	$75	$3,515.76	$1,401,596.95	$1,872,000.00	$470,403.05
10	$75	$4,408.92	$1,536,317.90	$1,872,000.00	$335,682.10
0	$100	$2,622.60	$1,461,876.00	$1,872,000.00	$410,124.00
5	$100	$3,515.76	$1,564,096.95	$1,872,000.00	$307,903.05
10	$100	$4,408.92	$1,666,317.90	$1,872,000.00	$205,682.10
0	$125	$2,622.60	$1,656,876.00	$1,872,000.00	$215,124.00
5	$125	$3,515.76	$1,726,596.95	$1,872,000.00	$145,403.05
10	$125	$4,408.92	$1,796,317.90	$1,872,000.00	$75,682.10
0	$150	$2,622.60	$1,851,876.00	$1,872,000.00	$20,124.00
5	$150	$3,515.76	$1,889,096.95	$1,872,000.00	$(17,096.95)
10	$150	$4,408.92	$1,926,317.90	$1,872,000.00	$(54,317.90)

[31] https://www.seniorliving.org/adult-day-care/costs/

It is important to note that the operational cost estimates included in Table 26 utilize cost of care estimates provided by ADHC programs in New York, Minnesota, and Hawaii. These three areas vary widely in terms of cost of living and health care costs. PCG reviewed cost comparison data across all four states from the Genworth "Cost of Care Survey 2019," a widely recognized industry benchmark.[32] While reported Adult Day Health costs were relatively similar in St. Louis and each of these areas, the costs for nursing home care is much higher in the other three location, in some cases double the cost of care in St. Louis. This indicates that in general, costs for care may be lower in St. Louis than those included in the conservative estimate presented here.

The following additional assumptions inform these estimates:

1. The program will operate 5 days per week, 52 weeks per year.
2. MVC would be responsible for transportation costs, as a rate of $40 per day per participant.
3. The cost for care is $200 per day per veteran. This figure was derived from discussions with other states who are operating ADHC programs (additional details can be found on page 46).
4. Daily copays do NOT apply to 70% SCD or higher veterans.

[32] https://www.genworth.com/aging-and-you/finances/cost-of-care.html

APPENDIX A – VSO OUTREACH INTERVIEWS

PCG conducted phone interviews with the following six Veteran Service Officers (VSOs) and supervisors in April and May 2019:

- David Lee (Supervisor), Kirksville, Northeast Region
- Katherine Flores, St. Charles, Northeast Region
- Lisa Helms (Supervisor), Farmington, Southeast Region
- Michael Probst, Cape Girardeau, Southeast Region
- Michele Taylor, Springfield, Southwest Region
- Paul Stone, Independence, Northwest Region

The following questions were asked during the interviewed with the VSOs:

- How many veterans are you working with at a given time?
- Do you carry an ongoing caseload?
- Tell us about a typical day and the kinds of activities it might include.
- How do veterans generally connect with you?
- What services and resources are available to you now to assist veterans?
- What are the areas where you are able to provide the most assistance to veterans?
- What services are veterans looking for that are challenging to you to provide?
- Which of those services would you prioritize? Which of these services would provide the most benefit to them?
- Are there other resources not currently available to you that would be helpful in assisting veterans?

APPENDIX B – RSMEANS COST ESTIMATE

The RSMeans construction cost estimate, referenced in the ADHC Cost and Benefits section of this document, is summarized here.

Building Type: Assisted - Senior Living with Brick Veneer / Wood Frame

Location: St. Louis, Missouri

Story Count: 1

Story Height (L.F.): 10.00

Floor Area (S.F.): 8200

Labor Type: OPN

Basement Included: No

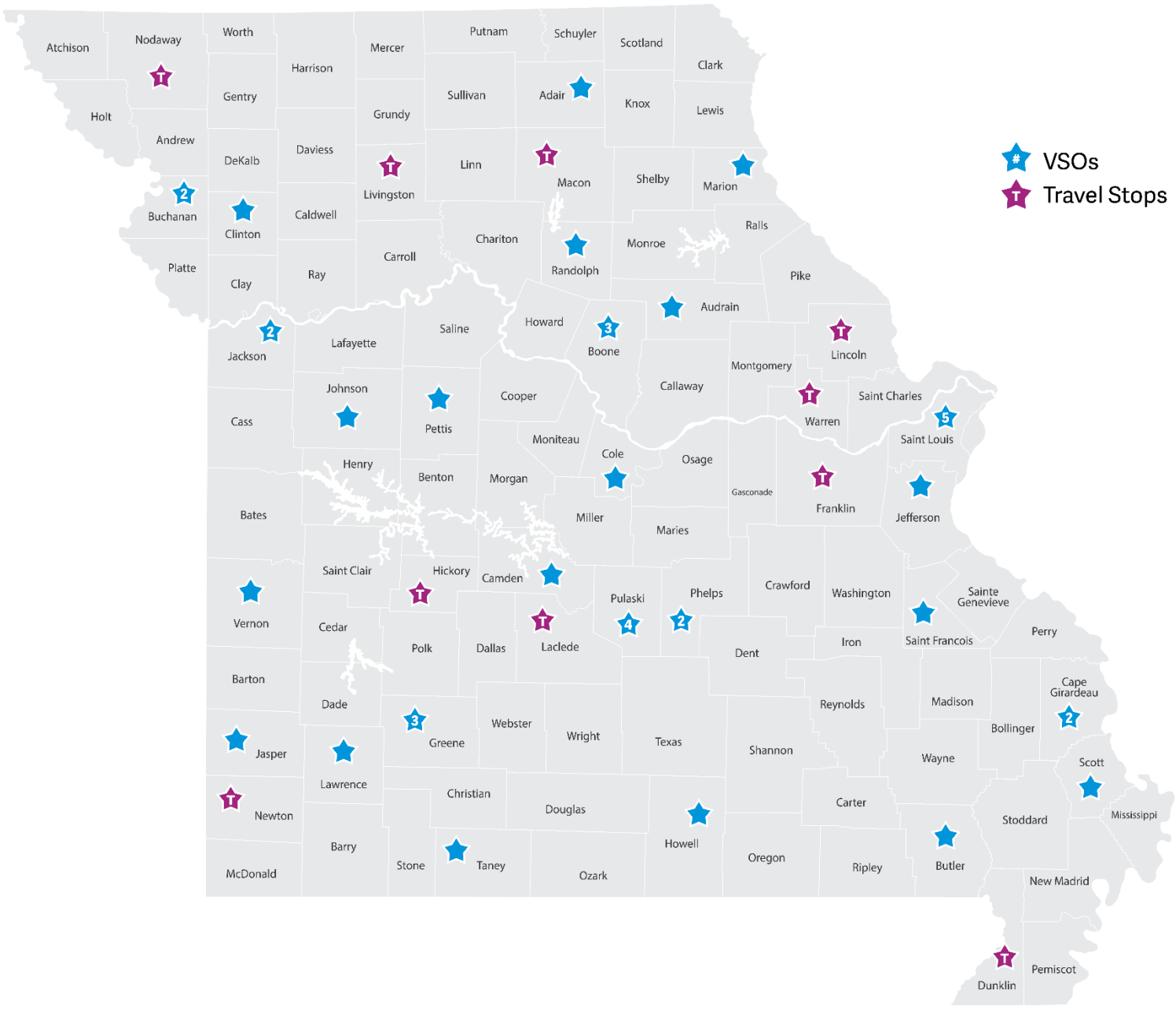
Data Release: Year 2019 Quarter 2

Cost Per Square Foot: $184.91

Building Cost: $1,516,287.40

Building Element	% of Total	Cost Per S.F.	Cost
Substructure	10.75%	$14.33	$117,476.56
Shell	20.13%	$26.83	$219,999.09
Interiors	25.12%	$33.48	$274,506.01
Services	42.78%	$57.01	$467,476.41
Equipment & Furnishings	1.22%	$1.63	$13,361.68
Special Construction	0.00%	$0.00	$0.00
Building Sitework	0.00%	$0.00	$0.00
Sub Total	100%	$133.27	$1,092,819.75
Contractor Fees (General Conditions, Overhead, Profit)	25.0 %	$33.32	$273,204.94
Architectural Fees	11.0 %	$18.32	$150,262.72
User Fees	0.0 %	$0.00	$0.00
Total Building Renovation Cost		**$184.91**	**$1,516,287.40**

APPENDIX C – MISSOURI MAP WITH COUNTY NAMES



Note: **Blue** stars indicate a permanent office where a VSO is located; a star with a number inside indicates that more than one VSO is sited at that location. **Purple** stars indicate "travel stops," where a VSO works at least one day per month.